Evaluation of the needle exchange program in correctional institutions in Catalonia

Executive Summary
Final Evaluation Report

Chair in Qualitative Research
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Introduction

The evaluation of the Needle Exchange Programs (NEP) in the Catalan prisons has been a learning-based evaluation. This means that, beyond looking into whether the program objectives have been reached, the emphasis was put on looking into what had helped and what had hindered reaching those objectives.

Regarding the impact of the NEP in prisons on quality of life in the prisons, there have been other studies and evaluations which have generated this evidence (see part 4.1. of the evaluation report). The objective of this evaluation was to identify the factors which condition, either positively or negatively, the level of participation in the NEP in the Catalan prisons.

It has been an analytical process, built on theory-based evaluation method (see 2.3 of the final evaluation report) which, like any other evaluation, has finalized with a conclusion (what helps and what does not help a good NEP?) and the statement of recommendations to make changes (what can we do to make NEP more efficient?).

Methodology

The NEP evaluation methodological coordination has been the responsibility of the Chair of Qualitative Research of the Dr Robert Foundation – UAB (CerQ). The guidelines of the process have been carried out in a supervised manner, within an Evaluation Monitoring Commission set up for this purpose.

This Monitoring Commission was made up of representatives of the Health Department and the Justice Department of the Catalonian Generalitat, of the prison government employees and of the prison health workers and of the treatment and rehabilitation services in the prisons.

Following the proposal by Hansen and Vedung (Hansen & E.Vedung, 2010) the work of the Monitoring Commission has been to lay out a plan for the evaluation based on the so-called Theory of Change in the NEP (see section 3.2. of the final evaluation report).

To do this, a comparison was done between what the driving agents of the NEP had wished for with what the rest of the involved agents thought was necessary to accomplish that1.

In this way, it has been possible to look at the NEP both from the desired results as well as from the point of view of the factors and circumstances which have conditioned their functioning.

1

With this goal in mind, several work sessions have been carried out in the Evaluation Monitoring Commission. First session (03/12/2009): Group work centered on analyzing in depth , the theoretical aspects of the NEP. Second session (16/02/2010): Group work centered on organizing the evaluation questions, defining the indicators and planning the field work necessary to get the necessary information.

To answer the questions related to the desired results of the NEP (what helps and what hinders the good functioning of the NEP in prisons?) it was necessary to identify the processes related to the program (informing about the program, access criteria, timetable, distribution, etc.) and the potential benefits and limitations of each of these.

To understand why these processes are understood (and carried out) in different ways in different prisons, it has been necessary to look into what meanings each group (clients and professionals) gave each topic such as drug use, harm reduction or the prison context.

Blending one with the other2 has allowed us to related certain process determinants with certain ways to understand the "drug use in prison" phenomenon, and it has set the basis on which to build a strategy for change focused on bettering the NEP (see section 5 of the final evaluation report).

To carry all this out, we have interviewed individually or in a group, health professionals, security professionals and rehab professionals of the prisons as well as inmates and former inmates, clients and non-clients of the NEP.

The sampling of the participants was theoretically representative (see section 3.3 of the Final Evaluation Report) and it is summarized in the following table.

Table 1: Number of participants in the NEP evaluation

Metodology: Participants

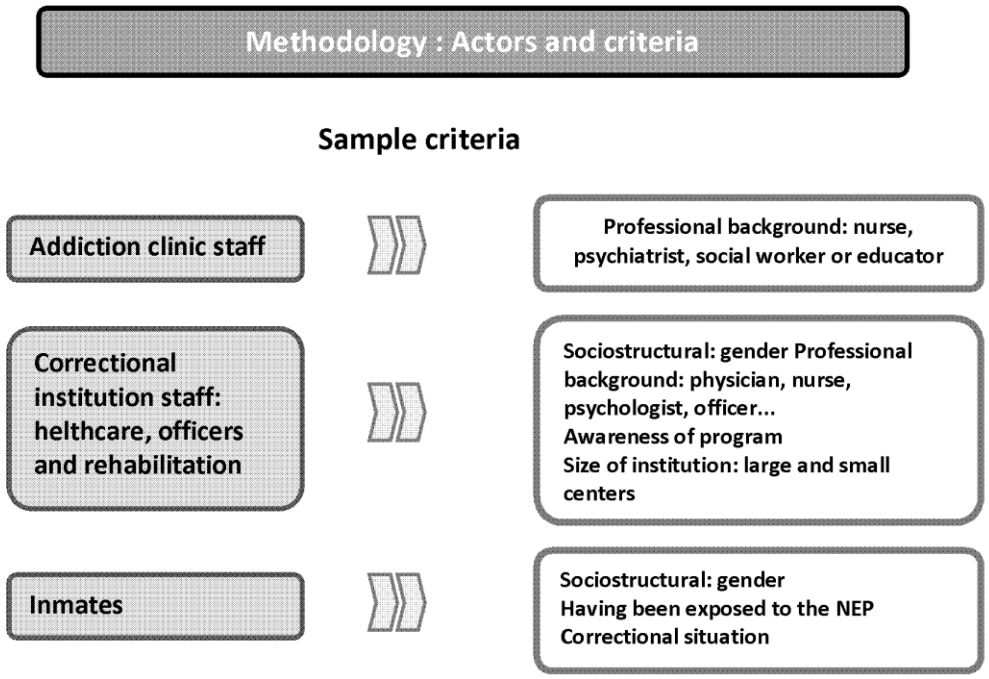
	Key informants	Addiction clinic staff	Health professionals	Prison officers	Treatment professionals	Inmates
Exploratory interviews	5					
Group interviews		2	4	1	1	
Individual interviews						13
Total participants	7	13	20	6	7	13
Total number of participants: 66						

The total number of participants in the evaluation was 66 and the profile distribution is summarized in the Table 2.

2

The repercussions of the methodological focus are that of a qualitative approach. That is to say, we gather information regarding the different meanings (narratives) which are found in prisons related to harm reduction and or drug use, and how these are related to certain practices (more or less convenient for the good functioning of a NEP). Yet we don't have the information on how often these narratives are repeated nor of its distribution amongst the population (clients and professionals) of the Catalan prisons.

Table 2



With the information that was created, Category and Theme Content Analysis and Narrative Analysis were done.

On the one hand, Category and Theme Content Analysis allowed to get a summarized view of the information, turning “raw data” into “useful data” from a dividing the texts and establishing categories that had a semantic relevance to the evaluation objectives.

On the other hand, the Narrative Analysis has allowed to pick out the heterogeneity of the meanings that the participants gave to drug use in prison or harm reduction, as well as to include the opinions of the professionals and of the inmates in the NEP evaluation.

Following, there is a summary of the main evaluation results. For the complete version, see section 4.2 of the Final Evaluation Report.

Results

1. Preliminary considerations

The evaluation has brought up issues of a varied nature which could explain the circumstances which condition the NEP functioning. These are issues regarding resources, context and even organizational issues.

But there is one issue which is the most importance, one which helps to understand the rest of the issues (contextual, organizational): the consequences of a certain way of looking at drug use in prison.

The fundamental issue has been that amongst professionals in prison there are different ways of understanding the phenomenon of "intervenous drug use in prisons", and therefore different ways of looking at harm reduction in general and NEP in particular.

What we mean is that many of the circumstances which condition NEPs can be explained depending on how the team in charge see this phenomenon in the prisons.

Example: to a certain extent, the organization of needle exchange programs is done in a certain manner depending on how the NEP team sees the "IV drug use in prison".

This being said, and to make the reading of the results more easily understood, the contents have been organized on the basis of three categories.

These categories represent three different types (stereotypes) of experiences. In another words, they show three different ways of understanding and prioritizing (by those involved in the program) concepts such as health, drug use or harm reduction.

These categories are theoretical representations (abstract) which do not aim to describe absolute nor set categories in which to distribute those involved in the program (the identity of those involved is made up of a complex set of circumstances which are not possible to describe under only one category).

They are categories which represent the narratives which are found in relation to the phenomenon in the prisons and they are the abstract categories in which people (professionals, inmates) tend to place themselves in relationship to the IV drug use phenomenon.

So, the idea is to describe three different ways of looking at the "IV drug use in prison phenomenon" that, although it may be a bit simplified, has helped to revised the NEPs from an evaluation point of view.

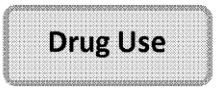
1.1. Infectious disease transmission

There is a first group of people who, when asked about "IV drug use in prison" built a narrative in which the main central problem was infectious disease transmission".

When a person spoke from this point of view, he or she communicated that the most problematic issue of the IV drug use in prison phenomenon was “the risks of sharing needles”. Around this issue one can find other topics such as drug use, rules, NEPs, the offenses or treatment. But always at the centre of the narrative, there is the problem of infectious disease transmission.

1.2. Drug use

Yet, for others, when they were asked about “IV drug use in prison” they built their narrative around “drug use” itself.



The aspect that they identified as most problematic as “that people in prison use drugs” and it is around that issue that other issues turned: needle sharing, rules, NEPs, etc.

1.3. Lack of control of the inmates

Finally, there are people who expressed the problem as being “the lack of control of the inmates”. The central idea of this narrative is the problematization of the fact that inmates might have spaces that are not controlled where they might use drugs o where they might access needles.

The autonomy (or rather the excess of autonomy) is the element which was seen as producing other problems such as drug use, needle-sharing, rules, etc.

As we will see, the majority of the key processes related to NEPs (acceptance of NEP in the prison, giving out information, access to the NEP, NEP organization, adherence of the inmates to the NEP, etc) will take shape depending, mostly, on the type of narrative that the professionals who are involved in the NEP organization in each prison have.

2. Summary of the evaluation results

Given the previous considerations explained above, we identify and briefly explain the factors that can help us understand “what helps” and “what hinders” a good implementation of the NEPs in Catalan prisons.

The results are illustrated with quotes taken from the analyzed material in order to enhance the readability of this text3

2.1 Acceptance of the NEP

The acceptance of the NEP has not been homogenous between all the agents involved.

The person who build their narrative around the problem of **infectious disease transmission** tend to accept the program without hesitation, claiming the importance of the right to health above all other considerations (such as, for example, if "drug use is damaging to health").

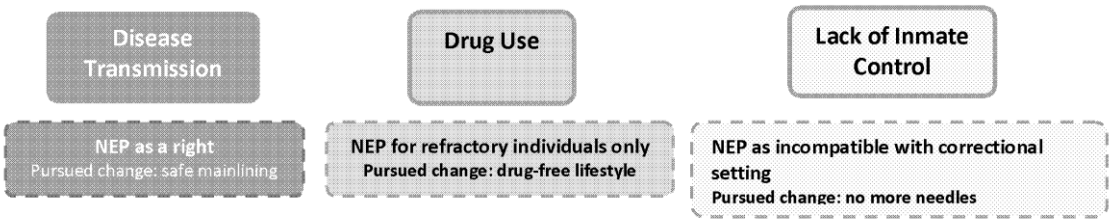
"*The same way he has the right to eat, he has the right to inject himself with a clean needle"* (GI1)

Those who build their narrative around the idea of **drug use**, tend to accept the program with some reservations. They accept the program because "if drug use cannot be avoided, it might as well be hygienic".

"So, there are other alternatives: you are a candidate for the NEP".

Those who build their narrative around the idea of **lack of control of inmates**, tend not to accept the program as it is organized. Their reasoning is based on the worry about control. To the extent that the NEP gives autonomy to the inmate, the NEP is seen as incompatible with the prison context.

"I cannot accept the program because before we had drug used under control and now we don't know what is going on" (FN)



2.2 Information on NEPs, access criteria and inmate responsibility

There are narratives that have put the emphasis on using all the means available to inform all the potential users of the program, directly or through posters.

3

CODING: **GI1**: First group interview with professionals. The number refers to the order in which the interview was done. There were 8 group interviews. **II1**: First individual interview. The number refers to the order in which the interview was done. There were 9 individual interviews done. **EII1**: First individual interview with an ex-inmate. The number refers to the order in which the interview was done. **FN**: Field notes.

"What I mean is that it is important that you inform them before hand and that they know that there is a NEP".(GI4)

On the other hand, there are those who have reacted negatively to giving out information. The thinking behind this is that a drug user already knows about NEPs because they exist out in the community and in all the prisons.

There are teams for whom access to NEPs has been an unconditional idea. They do not ask questions and they do not set conditions. They give out needles without any exceptions4.

"*The only assessment that it is done is* ***if you want to shoot up and you do not want to get infected, take a clean needle"***(GI1).

Yet, there are others who restrict participation in the NEP. They are teams (or professionals) who see the program as a last chance. The needle is given only in the case in which the inmate has not accepted alternative options.

"We also tell them that it is better if you change the way you use drugs and also I can put you on a methadone program…I see the program as the last alternative" (GI6).

In other situations, the access to the NEPs has been conditioned by opinion that the team has made of the inmate's decision about using drugs. If the decision is seen as acceptable (because it is a proven addiction) then the needle is given. If it is not considered acceptable (because the inmate is in a methadone program, because past drug use cannot be proven, because the inmate has had dangerous past behaviours, etc) they are not allowed access to the NEP.

"Those who ask through another person are also rejected and also people who have been involved in riots or in shit like that and do not have a clear addiction, they are not given needles" (GI6).

"If you are in a methadone program, I don't think you should use drugs so I am not giving you a needle" (GI6).

Finally, in other occasions, the access to the NEP has been conditioned by the will (need) of the professional to intervene therapeutically with the inmate.

"I respect that you want to ***go into a NEP, but on the condition that you participate in the health education program,*** *okay?" (GI6).*

Regarding the taking on of responsibilities: some experiences suggest that, within the limitations of a prison, the inmate has to be considered a responsible agent, responsible for his actions. It is taken for granted that the inmate will make his own decision about drug use and that his right to use drugs in a safe manner is enabled.

Other experiences, on the other hand, show clearly that the decision to use a clean needle is not in the hands of the inmates but in the hand of the professionals. The professionals at times feel responsible for the possible consequences that can arise from needle use and, in fact, they

4

There have been only exceptions in the case that the demand for a needle is from a pregnant inmate.

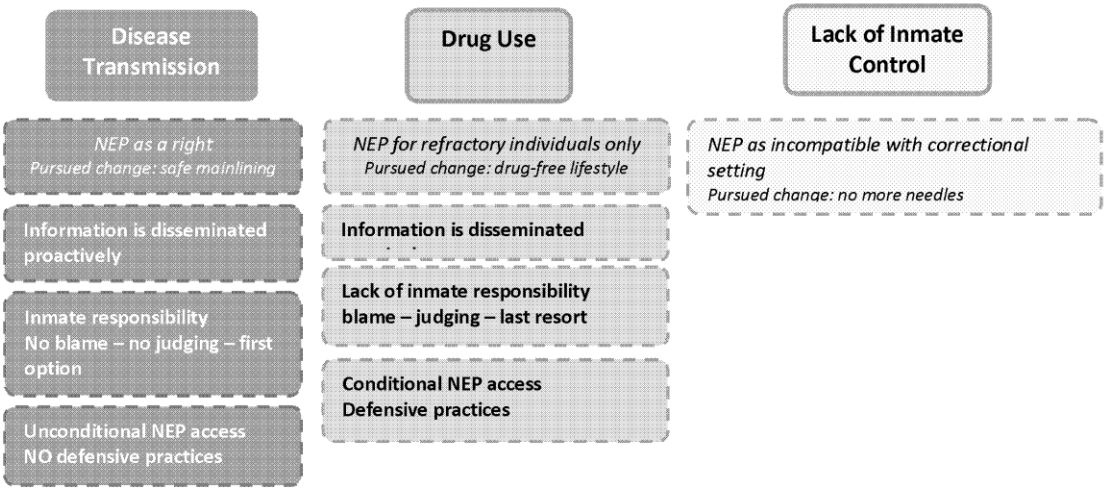
tend to describe themselves as the ones who are responsible for the consequences of the use of a needle.

This fact has conditioned health care delivery in general and the establishment of NEPs in particular.

This is mostly because there are fears, on the part of professionals of legal repercussions (this is so important that access to NEPs is often limited for this reason).

"This guy, you give him a needle and he does an overdose and if I were a family member I would say: hey, my son came into the prison alive and is coming out dead and you were the ones who gave him a needle (…) the one he died with. We have a responsibility for people's health" (GI5).

And secondly, because when inmates lose the capacity to decide over their own health, they start to feel that they don't own their health. When this happens, health becomes a negotiation issues which interferes with the relationship between professionals and inmates and it makes health delivery in prison very difficult (self-harm, lack of adherence to medication, etc).



2.3 Confidentiality and intake into the NEP

Sometimes confidentiality was a compulsory pre-requisite. That is to say that it is understood that participation is anonymous. This is reflected in that no written records are used, no notes are written and that inmates are given more than one needle to be able to give to someone who needs it (but does not want to identify himself to the institution), etc.

"I wish we could give two needles to the inmate, he might sell it or not, but he could give it to someone else" (GI1).

In other narratives, confidentiality is presented as a relative matter and what was before called "anonymous" now it is considered "secret"[5]. The registry and follow-up of the participants is justified for therapeutic or security reasons.

5

"I mean, when the inmates started in the NEP we would say to them, 'hey, don't worry, we will not tell anyone you are in the program and so on and so forth' but within a week the prison employees knew" (GI6).

The written version of the program discusses confidentiality (but not anonymous participation). It says that it is necessary to register, to monitor and, in the case of cell searches, to declare the participation in the program (in which case the confidentiality goes further and it includes staff that are not necessarily health professionals).

In closed settings such as prison, having confidentiality be of such fragile nature, has resulted in high levels of mistrust. In fact, one of the most common perceptions amongst the inmates and the professionals is that, inevitably, it is known who participates in the program.

"They never said to me: you have x number in your module. But we always knew who they were. I'd like to think we are doing our job well". (GI3)

Obviously, this deep feeling of lack of confidentiality has conditioned (and limited) the participation in the program for two reasons:

On the one hand, because as soon as it is known that someone is in the program, the whole situation becomes much less comfortable.

"Many left the program because they felt watched". (Not identified)

On the other hand, because it clashes with the behavior that inmates would rather have in prison: "in prison, the less you stand out, the better…"(not identified). The narrative shows that there is the belief that if an inmate is seen by the institution as a drug user, he or she will have a harder time getting prison benefits.

Between this, and what other participants have stated, very few inmates have been ready to give up prison benefits in order to have access to needles in a NEP through the established channels (instead they use other inmate's needles or they access the NEP in a clandestine manner). Let's see what an inmate says about this:

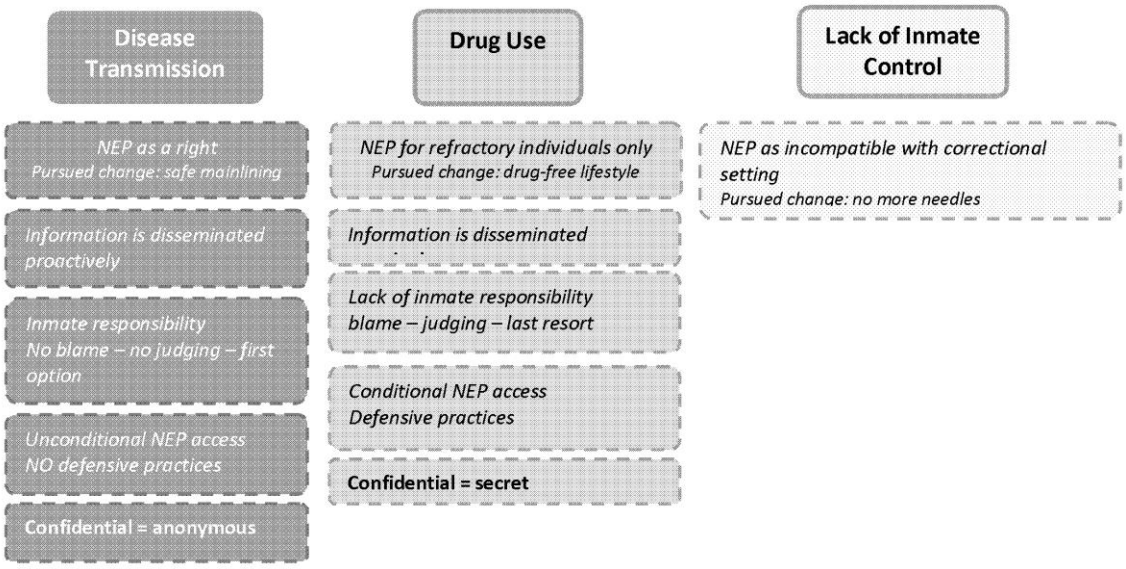
"When inmates think about the future, when they think that halfway through their prison sentence more or less, they get called for an interview to see how if you are ready to be released and all that, you worry whether that (the participation in the NEP) will come up". (II4).

At this point, and keeping the program's objectives in mind, the following question comes up: Who is going to participates in the NEP if part of the success in prison is to not stand out?

According to the statements made by the participants, it is normal to expect that the possible participants in the NEP will be restricted to those inmates who do not yet have the possibility of having access to prison benefits (or who have given them up).

While the concept of "anonymous" means that it is a person with an unknown name, "secret" means a person whose name is known but that it is revealed in a limited and save manner to various people (Spanish Academy Dictionary).

"Okay, look, I think the NEP is fine (…) for people who were like me before, who did not have any possible prison benefits, who still had years, (…) it was fine for me to be in the NEP (…) Now, people (…) with the possibility of early parole, (…) they are not going to go into the NEP, because they are afraid that they will find out and that they will say them hey! and harass them with urine tests, get it?" (II4).



2.4 The organization of the NEP

There are professionals who explain that the organization of the NEP has been done in the most possible flexible manner.

In these cases, the NEP is seen as a program that, first and foremost, has to guarantee access to the NEP's needles in the most wide and systematic way possible. Therefore, it has to function in an invisible manner at the same time that it has to keep in mind the realities of addictions (immediate access, etc).

"Since I have been here, I never call anyone, that is to say, the inmates come on their own, it is as though the outlet where I give them out ***is hidden from the prison worker's view"***(GI1).

"*The drug user, when* ***he has the drugs, the wants to use it*** *and to know how to manage all this in here and to be able to offer a needle at the right moment is complicated" (*GI2).

The goals of having the program be invisible and to meet the needs of addicts, the organization of the NEP should keep in mind flexibility of its hours and to have a good number of professionals available with the capacity of carrying out needle-exchange (which at times might include non-health professionals).

Despite this, some of the participants have affirmed that the current NEP plan does not help the NEP to be an invisible action nor does it adapt to the particularities of drug addictions.

"You have to go into the doctor's office, you have to ask for the key, and often, ***the keys are in the prison workers' office".*** (GI1)

"If I want to continue using drugs, I have to go back and ask that someone comes and gives me a needle, this takes time, time and ***it is not in fit into the needs of the drug addiction phenomenon"*** (GI2).

"We have a problem: between 9 pm and 9 am there is no health worker available" (GI6).

Other narratives do not see the organization of the NEP so problematic. Basically because it is seen as a space to continue using drugs.

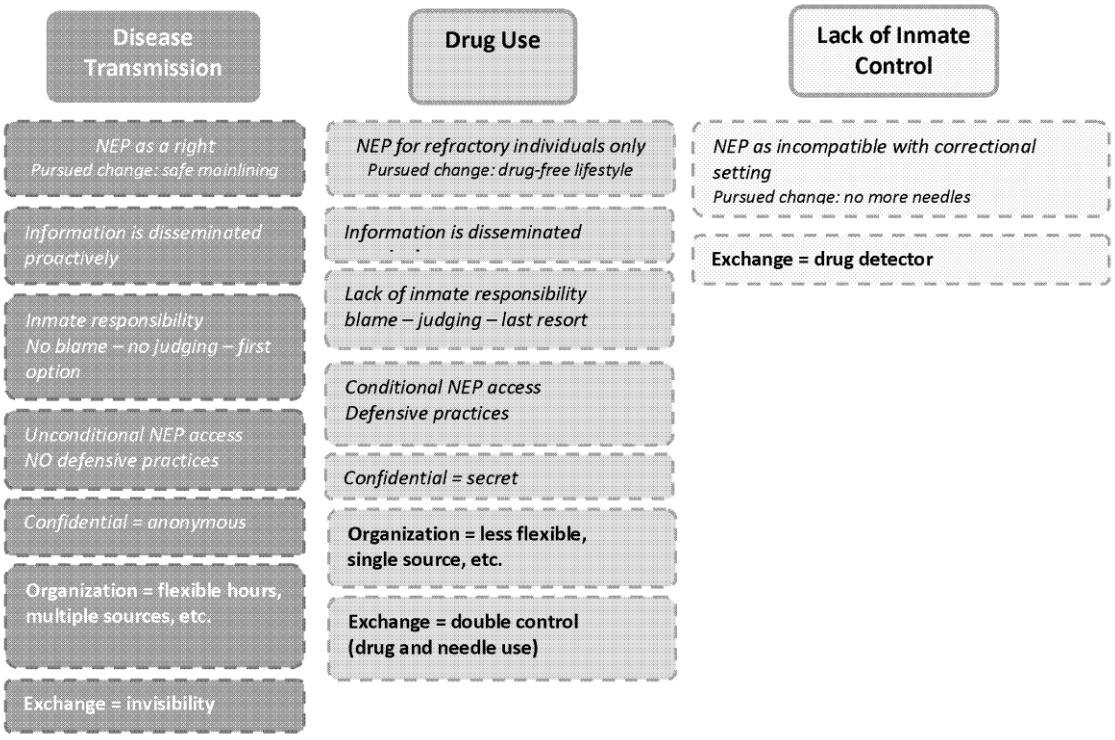
"The person has the right to go get a needle and it is controlled because he or she is interacting with a professional" (GI1)

Also it is seen as a space to detect the incorrect use of needles, a task which is in the hands of the professional (if the "control" issue is given more important before "maximum flexibility):

"You verify that the needle is okay…Or if you suspect that it is not for him or that it has been used several times, you consider it (excluding him from the program)" (not identified).

Finally, there is a third type of narrative which, when talking about the NEP, they describe it as a "possible pace" to find out who has drugs in the prison module.

"*I go after the one who has the needle, I watch the one who has the needle and I go to look for the one who is selling heroin"* (GI5).



2.5 Continuity in the NEP: the profiles of the inmates, the adaptation to the rules and trust issues

We have already seen that the access to the NEP is very limited to those who do not have a better alternative, and those who are still a long ways from prison benefits such as early parole. Yet, the same inmate in the program is able to handle a hard situation *"in which many want the needle that you have: inmates and guards".*

In another words, the way the NEP is organized now, this program is only really suited for those who do not have anything or much to lose , who know how to handle themselves in a context in which they have something which is limited and highly priced.

This refers to those who:

a) Are able to neutralize the pressure that other inmates put on them to let them borrow the needle.

"'We don't want needles' is what some inmates say because they bring on problems, problems with drug use, debts, fights, renting needles, whatever, people saying: 'listen, you go get a needle for me because I don't want them to know that I am shooting up" (GI2).

b) Know how to use their status as NEP clients to access other benefits (money, free drugs, etc.)

"Also, you should know one thing: the one who has the needle has more opportunities to get free drugs" (II4).

c) They live in a prison module where they feel that the pressure from the guards is less and it helps them live with the program in a normal manner.

"Then, depending on the prison module, there are conflicts with the guards…It's what I was saying: 'they (NEP workers) give the needle to you and we (guards) have to take it away' (…) then there are other modules which are calmer and easier to live in, to live years and the guards don't bother you so much" (II3).

2.5.2- Another fact which has helped to understand the continuity of the inmates in the NEP has been the type of application that is made of the rules.

There are professionals who, in order to facilitate the inmate's continuity in the program, are more flexible with the rules. They consider that being strict goes against the objectives and they modify the dynamics of the program to be able to handle the difficulties as they come up (for example, being flexible about keeping track of the needles given out).

"So we bent the rules a little bit, because the controls, as I say, were too strict and it made things worse rather than better" (GI6).

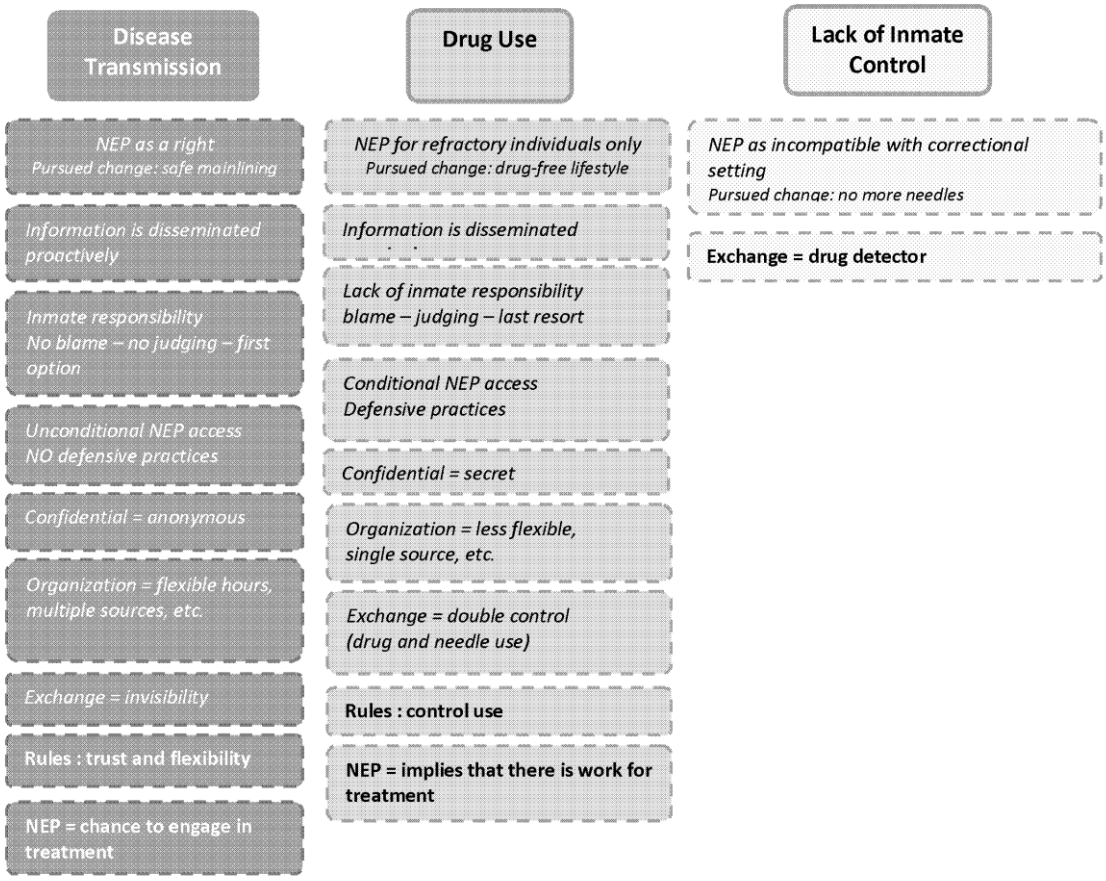
"We'd get a report saying that a needle was taken away from the inmate but we just gave it right back to the inmate" (GI1).

"Sometimes you have to explain to the inmates strategies such as when you shoot up you should clean it and up right back in the wrapper and you can say that it has not been used" (GI1).

On the other hand, there are professionals who would never consider exercising such flexibility. They say that the most important thing is to control the needle and that is the rule they follow in a strict manner. Basically they have not given any importance to the repercussions that this attitude might have in the inmate's continuity in the program.

"People are not careful and if you have a needle that is not controlled, then there could be accidents" (GI4).

Finally, there is a third factor that participants in the evaluation kept in mind when facilitating the inmates' continuity in the NEP. It is the "trust bond". Although it has been said that this therapeutic bond is not necessary to carry our harm reduction policies, it has been stated that, given the NEP's form and its implementation conditions, the establishment of a trust bond with the drug user can help them stay in the NEP.



Recommendations to improve the NEP

The theoretical logic of the NEP is unquestionable. There are a great number of experiences which have shown the positive effects of NEPs on the quality of life of prison inmates. The available evidence has emphasized that the distribution of clean needles contributes to reduce the use of non-sterilized needles and, as a result of this, to reduce the transmission of infections due to needle-sharing[6].

This evidence has been reinforced by the total amount of contributions made during the evaluation (coming from inmates as well as from professionals), and it has led to the general feeling that a NEP, well established, "is a program that avoids risk behaviors and it helps to reduce harms".

Yet, between 2005 and 2010, the global indicators in the NEP participation have put in evidence that, amongst the inmates who had said to have used injected drugs in the past, only 2.4% have ever used the NEP (see Annez 2, Table 3 of the Final Report).

Although it is true that not all those inmates who had been needle drug users also used drugs in prison, it is also true that (according to the evaluation results) that:

- Needle drug use in prisons is still a reality, and
- That not having injected drugs before or being in a methadone program does not necessarily mean that the inmate does not inject drugs.

Faced with this, and to try to understand such low NEP participation numbers, we have looked in depth the logic for setting up NEPs (to see which processes have helped or hindered the proper implantation of the program).

From this analysis of the results (see section 4.2) and from the work done on the results (Evaluation Monitoring Commission[7]), two main lines of thought emerged focused on making more compatible the prison logic (treatment for rehabilitation) with the harm reduction logic.

These two lines of thought faced fundamental questions regarding NEP, such as "the nature of its objectives" and "the access procedures and the needle management".

6

There are many useful references regarding the evidence at the international level in relation with the efficacy of the needle Exchange programs in prisons (see part 4.1. of the Final Evaluation Report). When it comes to the good results of the NEPs in Spanish prisons in bettering the quality of life of the inmates, we would like to highlight the 2003 publication by the *Subdirección General de Sanidad* (Sanz et al., 2003); or the NEP evaluations like the one done in Bilbao (Menoyo et al., 2000) or the one in Pamplona (Villanueva, 2002).

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On October 21, 2010, the Evaluation Monitoring Commission's Third Workshop took place. The objective of this workshop was to define the possible reorientations that would have to be applied to the prison NEP programs, keeping in mind the preliminary results of the evaluation.

The rethinking of these issues opened the door for possible major changes to the NEPs, but it also made clear that these NEPs are being carried out in a complex content where changes need time and a process.

For this reason, to the first two lines of thinking, a third one was added, a whole line of considerations which we have named “transition issues”.

These are recommendations that given the evaluation results, do not have enough strength to change the low participation in the NEPs. Yet, in a context in which there would be a progressive and global transformation of the NEPs (that would take into account the first two sets of recommendations), could contribute to make the change easier.

All these issues have been discussed and analyzed in the Evaluation Monitoring Commission (see section 3.2), and as the result of this work done different sceneries have been thought out about which there should be decisions made in order to make changes and improvements.

Decision 1: The NEP goals

The results of the evaluation motivate us to recommend that decisions should be made regarding the explicit objectives of the NEPs.

We have had the opportunity to see that harm reduction (and NEPs in particular) are phenomenon which can be understood in very different ways by the prison professionals.

On the one hand, there are professionals who understand harm reduction (NEP) as the last stage of a therapeutic strategy oriented to avoid the fundamental problem: drug use.

In these cases, the relationship with the drug using inmate is focused on the therapeutic strategy of abstinence. Under certain circumstances, giving out a clean needle is considered, but this act is always part of and secondary to a larger therapeutic process focused on rehabilitation.

On the other hand, there are professionals that understand harm reduction as a strategy that make sense all by itself. In fact, for them, the NEP is not seen as a strategy, it is seen as a right, and it is implemented parallel to other rehabilitation processes.

In these cases, we can see two independent lines of work: on the one hand actions to avoid transmission, and on the other hand actions to support the person in rehabilitation.

As can be seen in the evaluation results, when the NEP is seen as one more phase of a therapeutic strategy oriented towards abstinence, the access to the program is more difficult (and there is less information available as they do not want to encourage drug use, the requirements to enter the NEP are stricter, etc.) and it is harder for the inmates in the program to comply (there is less flexibility with the rules, etc.).

Recommendations on decision making

The written NEP text now being used, did not facilitate that the program be seen by all professionals as a harm reduction strategy that makes sense just on its own.

Although the idea behind the actions of the Department of Health and the Department of Justice of the Generalitat de Catalunya has a clear harm reduction focus, the actual written version of the NEP[8] has contributed to, at times, having professionals see needle exchange as one more part (the last recourse) of a therapeutic strategy focused on rehabilitation.

It is recommended that the written version of the program be revised keeping in mind these considerations, and to describe in an explicit manner the NEP as a harm reduction strategy, focused on avoiding the transmission of infectious diseases, which is implemented at the same time as other therapeutic rehabilitation strategies that might be considered relevant.

It is recommended that, based on the above, it be made explicit in the written version of the program, if certain circumstances (participation in the methadone maintenance program, etc) or past history (no past history of drug use, dangerous behavior, etc.) can result or not (and how much) restrictions to access the NEP.

Decision 2: Access to needles

The evaluation results motivate us to recommend that decisions be made regarding the mechanisms of access to needles and the role of professionals in needle exchange.

Right now, between the drug using inmate and the clean needles there is a professional (health worker) who acts as a go-between (in the access and the management of the needles).

This contact with the professionals is highly valued (by both the professionals and the inmates) when a therapeutic bond is developed between them (formal or informal). But it is not so when the inmate would rather have access to needles avoiding whatever relationship with the institution.

In these situations, and independently of how the professional team might have conceptualized the NEP[9], the present system has resulted in a series of problems.

8

Right now, one of the explicit objectives of the program is "To potentiate a change in how drugs are used" and it includes, amongst the tasks of the professionals that of "motivating the drug user to make changes and to develop healthy habits".

9

That the health professionals become go-betweens in the access to needles, several situations have played a part such as:

- It could be that the professionals understand that the NEP is unconditional, or that it is secondary to the larger therapeutic logic of rehabilitation.
- It could be that the professionals contribute to the belief that the inmate is responsible for his or her drug use (and its consequences), or maybe the idea that the inmate is not responsible for his or her own health decisions might gain strength.
- It could be that the professionals might not be scared of the possible legal repercussions that come from handing out needles, or that they express defensive practices in order to protect themselves from possible repercussions.
- It could be that professionals verbalize strategies in which the inmate and his use of the NEP be done in an invisible manner, or that they prioritize controlling strategies which make the inmate more "visible" to the institution.

Where the professionals put an emphasis on facilitating the maximum access and continuity to the NEP, they have had to do a series of balancing acts (logistical and normative) which in normal conditions would not have been necessary (and that did not always allow the adaptation of the NEP to the particularities of the addiction phenomenon: timetables, immediacy, etc.).

Where the professionals put an emphasis on using the NEP as a tool to help the inmate in his or her rehabilitation process, the NEP becomes contaminated with a rigidity (logistic and normative) which makes participation and continuity difficult for the inmates (lack of trust, lack of adaptation to the addiction phenomenon, etc.).

Recommendations for decision-making

Given the circumstances in the prisons (where invisibility is a value held in high esteem by the inmates), we recommend complementing the present system of needle distribution (which is well valued by the interns who want to establish a bond with the professional) with a simplified system of needle management where access is more direct and where there is no need for go-betweens.

We recommend to study the possibility of transferring to Catalonia the solutions adopted in other countries (Switzerland, Moldavia, Kyrgystan or Bielorussia) where with the wish to solve the problems related to the participation of health professionals in the distribution of needles, they have adopted systems of anonymous access to needles (automatic dispensation or peer-to-peer distribution).

In this way, we pay attention to the conclusions that we have received from the evaluations. The German prison NEP evaluations in Vechta and Lingen (Stöver, 2000) conclude that where the needle exchange has not been mediated by a professional, the program has enjoyed more acceptance.

Like in Catalonia, in German prisons where the needles are distributed by health workers, there are a group of inmates who are reluctant to participate in the NEP because they do not want to be seen as drug users in the prison.

The same conclusions were reached in the analysis of NEP in countries like Moldavia (Hoover and Jürgens, 2009), Kyrigyzstan (Lines et al., 2006) or Bielorussia (Savischeva, 2003).

Decision 3: Complementary measures

In the context of prison treatment, the lack of abstinence of a person imprisoned for being charged with something related to drug use, is considered a potential factor in the inmate committing the same crime.
This takes place in a complex situation where evidence that there is drug use strongly conditions the progressions and set-backs in the ladder of prison benefits. This is so important

- It could be that the professionals allow clandestine strategies to access the NEP, or that they limit the participation in the NEP to the confidentiality clauses established in the program.

that in prison, any proposal to carry out harm reduction activities have to avoid been seen by the interns as a possible way of putting in evidence their status as drug users which would put in danger their access to prison benefits.

Because of this, the two previous recommendations have put an emphasis on keeping the distribution of needles away from any therapeutic process, and far away from the "eyes" of an institution which, for better or worse, also made up of health professionals with many different ways of understanding harm reduction.

Yet, the results of the evaluation lead us to recommend that decisions be made regarding a series of issues that, although they, by themselves will not transform the deeper problems, they could help to take steps in the right direction.

Some of the issues are:

- Raising awareness of the political leaders and of the prison directors towards the human rights related to harm reduction programs.
- Raising awareness of prison professionals about how harm reduction programs work.
- The relevance of transferring experiences and knowledge between community NEP professionals and prison professionals.
- Work on the dynamics which might help inmates to take more responsibility for their health.
- Rethinking the concrete processes of access to needles when they are distributed by professionals (timetables, authorized professionals, etc.).

Decision-making recommendations

3.1 Raising awareness and training on harm reduction programs.

The evaluation has put in evidence a wide range of interpretations (and experiences) regarding harm reduction.

In fact, different professionals have shown that they do not have enough personal resources to integrate in their work what is still seen as a negligence: "*to allow someone to user drugs without doing anything to prevent it".*

In the Evaluation Monitoring Commission, it has been considered that in order to integrate a harm reduction perspective in all prisons, it is necessary an intervention at two levels.

On the one hand, it is necessary to raise political awareness amongst those responsible for the NEPs and prisons.

On the other hand, it is necessary to carry out a systematic training program for all professionals (health and other) who work in prisons, which would include the phenomenon of drug addictions in general and harm reduction in particular.

Another line of work to consider would be the creation of alternate spaces (such as workshops and congresses) designed with the objective of sharing experiences between professionals who work in the community and those who work in prisons, with the objective of encouraging knowledge exchange.

3.2 Responsibility of inmate drug addicts

One of the circumstances that, as we have seen, comes up depending "who" is looking after the NEP, is the greater or lesser responsibility that is given to the inmates when it comes to making decisions.

Sometimes not allowing responsibility is done in a subtle manner (not allowing access to the NEP to those in methadone), and in other less direct manner (defensive behaviors as a result of the professional's fear of legal repercussions).

For these more direct circumstances, the Evaluation Monitoring Commission recommends to assess the advantages and disadvantages of including, in the participation contract, a clause which makes the inmate who uses the NEP responsible of the consequences of needle use (overdose, etc.).

3.3 Access to needles

The evaluation has shown that the access to needles which is mediated by health professionals has disadvantages of a different nature: distrust from the inmates, difficulties to adapt to the addiction phenomenon (schedules, immediacy, etc.), restriction to NEP access from some of the professionals, etc.

Despite this, and in the larger and progressive transformation of the NEP, it is recommended that while the needle distribution continue to be done by professionals, the program should adapt as much as possible to the addiction phenomenon: access to needles any time, and the faster the better.

It is suggested that the advantages and disadvantages of increasing the number of professionals be considered, professionals who, at any given moment can become needle exchange agents in the prison.

It is recommended that the advantages and disadvantages of increasing the number of needles distributed in each exchange be considered. It could be interesting to look into the experiences such as that of the Swiss prison in Hindelbank where, along with the syringe, 5 needles are given out systematically to be used before the next exchange[10].

3.4 Material in the NEP kit

During the evaluation process, several participants have pointed out the deficiencies in the material in the NEP kit. Concretely, it has been pointed out the lack of a spoon or cooker to prepare the mixture. This deficiency has been a source of concern because it has forced inmates to share material with other drug users or to have to reuse material about which there was no guarantee that it had been manipulated in a hygienic manner.

10

With the idea of avoiding re-use of the needles given out by the NEP, the Swiss prison of Hindelbank gives out, with each syringe, 5 clean needles. This action has not caused any problems in prison security. (Lines et al., 2006).

It is recommended that the advantages and disadvantages of increasing the material in the kit be reviewed.

Evaluation of the needle exchange program in correctional institutions in Catalonia

Final Evaluation Report

March 2010

1. Introduction

The evaluation of the prison Needle Exchange Program (NEP) in Catalonia has been one centered on learning. This means that beyond exploring whether the objectives of the program have been reached, the emphasis has been put on looking at *what has helped and what has hindered* its development.

When it comes to the relevance of the NEP as a harm reduction program in prisons, other studies and evaluations have already generated the necessary evidence (see section 4.2 of the Final Evaluation Report). This being said, the objective of the evaluation has been to identify the circumstances which have conditioned, positively or negatively, the level of participation in the NEP by drug using inmates in the Catalan prisons.

It has been an analytical process, built on a theory-based method of evaluation (see section 2.3 of the Final Evaluation Report) that, like any other evaluation, has ended with an global assessment of facilitating factors and obstacles and the statement of recommendations for change.

The evaluation report is structured in four sections.

In **the first section** presents the conceptual evaluation framework, consisting of four parts:

- The first part briefly reviews the different program and public policy evaluation models.
- The second and third parts present the conceptual frameworks used for the NEP: Learning-based evaluation and theory-based evaluation.
- Lastly, and to close of this section, the object of the evaluation is described: The NEP.

In **the second section** deals with the evaluation and structure of the evaluation in two parts:

- The first part presents how the evaluations questions were developed: NEP change theory.
- The second part describes how these evaluation questions were answered: the field work.

The **third section** deals with the evaluation results and it is structured into two sections.

- The first section deals with the results of the “theoretical logic” of the NEP, that is to say, the results that inform us if the NEP is a good tool to improve the quality of life on the inmates.
- The second one refers to the “implementation logic” of the NEP, that is to say, to the results that inform us of which circumstances help and which hinder a good implementation of the NEP in the Catalan prisons.

The **fourth section** closes the report with conclusions which sum up the recommendations to improve the program, which have arisen during the evaluation.

2. Theoretical framework of this evaluation

2.1. Program and public policy evaluation models

The evaluation of public policies and programs is a discipline which is based on asking and answering questions with two objectives. On the one hand, there is the goal of giving an opinion regarding the object being evaluated and, on the other there is the need to make recommendations for change and improvement.

But, of course, the idea is not to answer any question nor to do it in any manner. The idea is to answer questions which will be relevant when it comes to determining the value or the merit of an intervention, according to a systematic and rigorous methodology (A J Shinkfield & D L Stufflebeam, 1995).

Throughout history, the interest that has traditionally shaped the "need for facts" of the evaluation of public policies, has evolved with the models that have changed this field of research during all its years.

While during the beginning of the 20th century the preferred evaluation model was mostly concerned with measuring the relationship between the results and the program objectives (Tyler, 1949), starting in the 1960s the evaluation questions were more pragmatic. From then on, evaluation has ceased to be a tool designed to only verify if the objectives were being carried out, and new evaluation questions were posed that looked for "unexpected effects" and to find out "what has to be done" to improve the evaluated policies (Cronbach, 1963; Scriven, 1972).

From then until now, there have been various authors who have classified the existing evaluation models based on the types of questions and the point of view which each model has stressed (ideology, epistemology or methodology).

In any case, according to the different classifications suggested with the years (Ballart, 1992; Guba & Lincoln, 1989; Monnier, 1990; Patton, 1990; Shadish, Cook & Leviton, 1991; DL Stufflebeam & AJ Shinkfield, 1987, E Vedung, 1997), the concepts and ways of evaluating have changed following the prevailing scientific paradigms (this became particularly obvious in the second half of the 20th Century).

The art of evaluation has gone from asking one's self questions that required rationalistic models (Campbell, Stanley & Gage, 1963) and semi-experimental designs based on the experimental scientific method[11](Suchman, 1967), to concepts that are more relativists and

[11] Bunge defines the scientific model by its factual, rational, verifiable, objective, systematic and explicative method. It is factual to the extent that it deals with empiric facts and phenomenon. It is rational because it is based on a group of ideas and reasonings and not on sensations, opinions, thoughts or dogmas. It is verifiable in the sense that in can be verified empirically. It is objective because its affirmations try to be coherent with reality. It is systematic in the sense of building a body of logical ideas. And it is explicative in the sense that it does not satisfy itself with describing what the world is like, but tries to identify the reasons why the empiric phenomenon behave the way they do. (Bunge, 1988, page 10).

sensible to the context circumstances (DL Stufflebeam & AJ Shinkfield, 1987), that demanded an evaluative practice that answered questions related to the nature of the policies and to the necessary procedures to implement the evaluated programs (Weiss, 1972).

The evaluation models have ranged from those whose top priority was the creation of useful information that can be classified, retained, processed and used by the agents involved in the program (Patton, 1997), to other models known as "fourth generation" (Guba & Lincoln, 1989) which try to find answers to sensitive evaluations questions and to the concerns of the "stakeholders"[12] , as well as the concerns of the professionals involved in the daily management of the program (Stake, 1983).

In any case, there have been various authors that see the evaluation discipline of the past century as a voyage that, having its roots in questions aimed at proving the efficacy of programs (understood as statistically significant changes in measurable quantitative outcomes), it evolved towards models that try to explore the "how" and the "why" of a program, "for whom" it works and under "which circumstances" (Weiss, J.I. Connell, A.C. Kubisch & L.B. Schorr, 1995).

The result of this voyage has come together now at a time where various points of view and ways of doing evaluation cohabit together, where the efforts fluctuate between the need to verify the efficiency of the programs and the need to learn to about the work done and so improve the way that policies transform the world.

2.2. NEP evaluation: A learning-centered perspective

Learning-centered evaluation engages mostly in understanding the motives which explain program results. It concerns itself with drawing lessons from the work done and to generate processes that can result in improvement.

It is a type of evaluation which tries to identify and understand the effects of the interventions as well as the elements and the circumstances that have conditioned them, incorporating, not only the knowledge of those involved (agents), but also the meanings and interpretations that they attribute to the elements of the program being evaluated.

It is built on the basis of the interpretative-constructionist paradigm, and it bases itself on the belief that reality is neither just "one" nor can it be studied "part by part" (variables).

It is taken for granted that "reality" is nothing else than the sum of "realities" that live in the mind of individuals, that reality responds to one or various psycho-social constructions (often problematic and changing) have to be dealt with in a holistic manner, with the objective of showing the values, the beliefs and the attitudes behind it.

As a result of this, the evaluation based on learning is based on recognizing the social realities which exist as mental constructions specially around the program being evaluated that can be

[12] The word "stakeholder" refers to the English expression used to refer to organizations, groups, clients or beneficiaries involved in the evaluation process. Generally, these interest groups are formed by people with similar characteristics (professionals, planners, clients, etc.) who have some interest in the outcome, in the product or the impact of what is being evaluated. That is to say, that they are in some way involved or potentially affected by the program and by the possible consequences of the evaluation program.

discussed, negotiated, shared, reformulated and prioritized with the objective of answering evaluation questions related with the processes of implementation of the program and not exclusively to their results (Vélez, 2006).

2.3. The method: Theory-based evaluation

The contributions made by Carol Weiss relative to the evaluation method based on Theory, have served as a starting point for the evaluation of the Needle-Exchange Program in Catalan Prisons.

Evaluation based on theory has as its starting point in the idea that all programs are based on a theory, on an intellectual process that explains how and why this program works. This intellectual process involves a laying out in detail of the underlying strategies of the program being evaluated (i.e. the explicit or implicit theory that feeds its practices and ideas).

"It is an approach to evaluation which requires a detailed review of the ideas on which a program is designed: activities, foreseen results of each activity, reactions and follow-up steps, etc., up to the expected results. After that, the evaluation explores each one of the steps in the sequence to verify if each one of them has materialized" (Birckmayer & Weiss, 2000, page 408).

From this point of view, revealing the theory behind a program means stating "what is expected to happen" during the intervention phase and as a result of the same. That is to say, what theory of change is being endorsed or, in another words, which is the logical, possible and reasonable way in which certain program goals are expected to be reached (Bickman, 1987).

3. NEP Evaluation Design

3.1. The object of the evaluation: The Catalan Prison Needle Exchange Program

The Needle Exchange Program of the Catalan prisons, launched by the Generalitat de Catalunya (Health and Justice Departments), is a harm reduction program for the drug addicted population of the prisons, with the objective of avoiding risk behaviors (sharing needles between inmates); preventing infectious diseases related to IV drug use (HIV and Hepatitis infections, etc.), and to encourage the development of healthy habits and behaviors amongst drug user inmates.

With the setting up of the NEP, health professionals give out injection kits to the inmates who ask for them (and who meet the requirements to be in the program), as long as they return the needles that they took previously. This exchange takes place in a personal manner and in a space which allows to work on other health issues with the drug addict.

It is important to underline that the program is carried out in a setting (prisons) that have rules which not only punish possession and use of drugs, but that it also, for security reasons, also considers needles non-authorized objects.

Because of this, and to allow the possibility of carrying out a NEP, the norms of each prison were modified so that having needles was allowed in the terms described by the program.

3.2. Designing the evaluation

According to the theoretical frameworks described above (see section 2), the evaluation of the NEP in prisons has been designed one two basic premises:

- On the one hand, the NEP evaluation had to be built on the representations (meanings) that those involved had about the program and not on the ideas that the evaluators might have had based on the written proposal of the program.
- On the other hand, the involvement of the different agents would involved that the different ways of interpreting the objectives and the functioning of the program be made explicit (Sullivan & Stewart, 2006).

Both premises have been seen as fundamental when it comes to building a significant evaluation for those who will be using the results in the future (Green & McAllister, 2002).

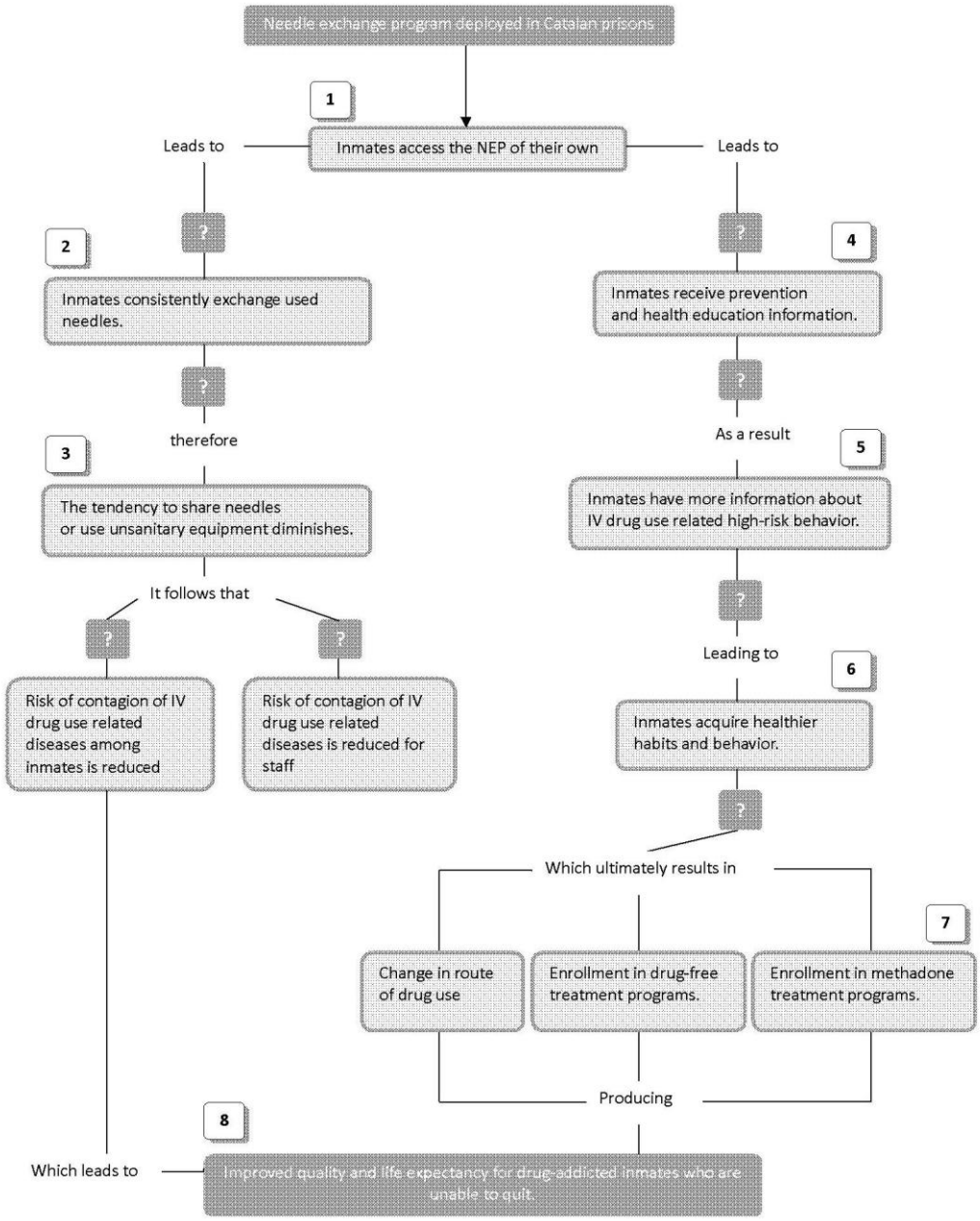
To make these premises concrete it has entailed:

- On the one hand, the inclusion of the different collectives involved in the program in the design of the evaluation. To this end, the **Evaluation Monitoring Commission** was set up, which was made up of representatives of the Health and Justice Departments of the Generalitat de Catalunya, a collective of prison workers, a collective of prison health workers and treatment and rehabilitation workers.
- On the other hand, the need to overcome some of the recently identified limitations in the use of the Theory-based evaluation (Rogers & Weiss, 2007), and to distinguish clearly between **the theoretical logic of the program** (program theory) and **the pragmatic logic** of the same (implementation theory).

According to Green and McAllister's proposal, CerQ's methodological team built, on the basis of the available documentation, a first draft of the **program's theoretical logic** (NEP's program theory).

This first draft (see Chart 1) put in evidence the logic that "explained" the causal mechanisms through which the expected results were generated (intermediate and final results).

Chart 1: NEP theory



Based on this first draft, the first working meeting of the Evaluation Monitoring Commission was carried out, with the objective of exploring in depth this preliminary work and to have the **NEP pragmatic logic** come out.

- **Session 1** (December 3rd 2009)**:** Work was done on analyzing in depth the theoretical logic of the NEP. The program's "black boxes" were explored, in another words, the factors and circumstances that, in the opinion of the members of the Commission, were indispensible elements so that the theoretical logic described above could become reality.

Also 5 in-depth interviews were carried out with professionals in the different areas close to the program (health, security and rehabilitation). The different circumstances that, represented

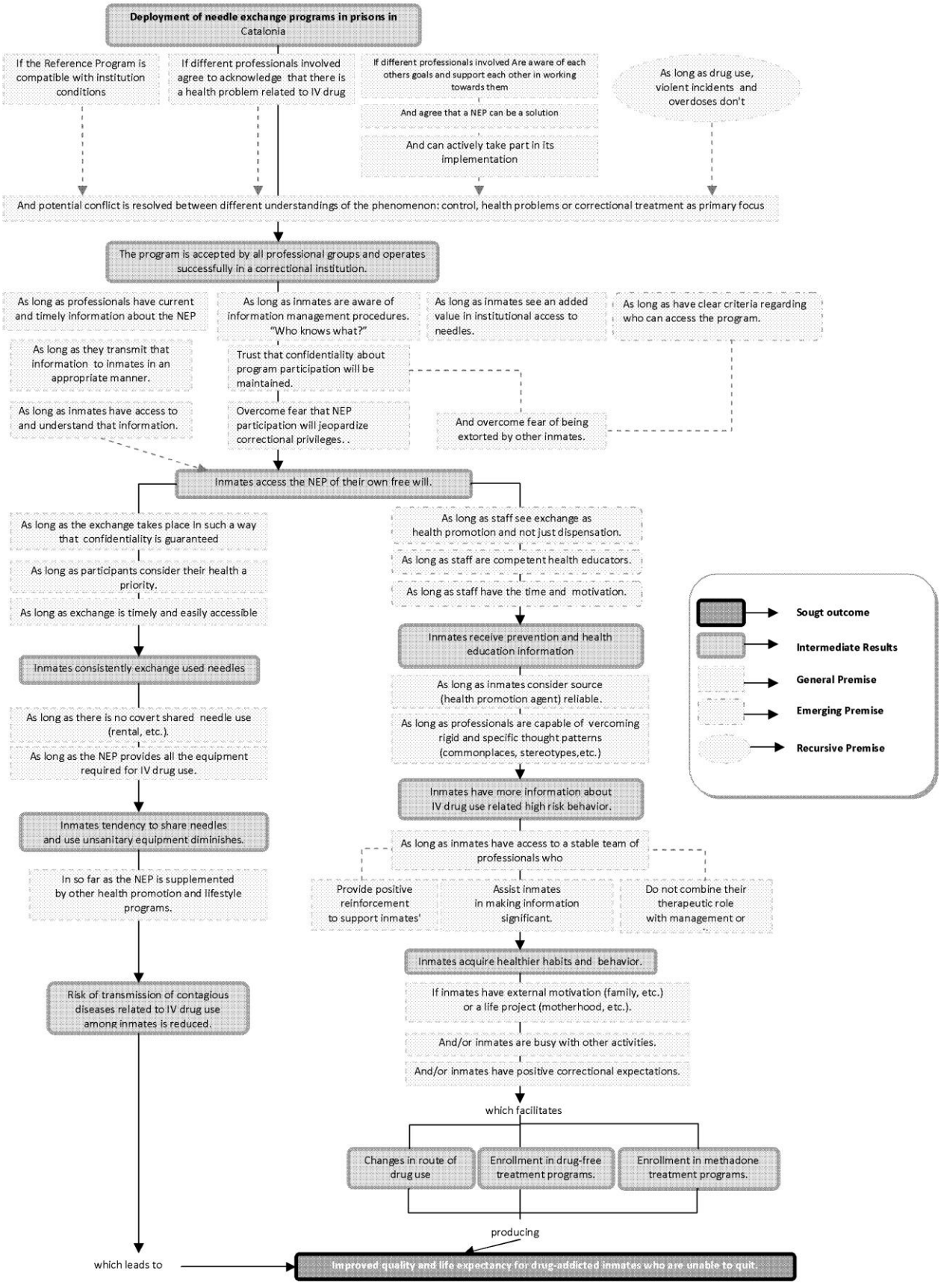
by the black boxes of the **program theory** (see Chart 1), necessary to reaching the various results (intermediate and final), were explored with them.

The role of these black boxes reminded us that there was a set of circumstances which had to exist with the aim that the program become a working service. In another words, the black boxes represented a series of premises (that **the program theory** does not gather) that were necessary if the logical sequence of the NEP was to take place.

These premises are, what is called, **implementation theory**. They are the processes, the resources, the context circumstances, etc. that have to be present in order for the logic that was proposed in the **program theory,** to be able to be possible in each one of its steps.

The overlapping between the program theory and the implementation program permitted to represent (see Chart 2) what is called **change theory** of the NEP (A Kubisch, Weiss, LB Schorr & JP Connell, 1995).

Chart 2


Deployment of needle exchange programs in prisons in Catalonia
If the Reference Program is compatible with institution conditions
If different professionals involved agree to acknowledge that there is a health problem related to IV drug
If different professionals involved Are aware of each others goals and support each other in working towards them
And agree that a NEP can be a solution
And can actively take part in its implementation
As long as drug use, violent incidents and overdoses don't
And potential conflict is resolved between different understandings of the phenomenon: control, health problems or correctional treatment as primary focus
The program is accepted by all professional groups and operates successfully in a correctional institution.
As long as professionals have current and timely information about the NEP
As long as inmates are aware of information management procedures. "Who knows what?"
As long as inmates see an added value in institutional access to needles.
As long as have clear criteria regarding who can access the program.
As long as they transmit that information to inmates in an appropriate manner.
Trust that confidentiality about program participation will be maintained.
As long as inmates have access to and understand that information.
Overcome fear that NEP participation will jeopardize correctional privileges. .
And overcome fear of being extorted by other inmates.
Inmates access the NEP of their own free will.
As long as the exchange takes place in such a way that confidentiality is guaranteed
As long as participants consider their health a priority.
As long as exchange is timely and easily accessible
Inmates consistently exchange used needles
As long as there is no covert shared needle use (rental, etc.).
As long as the NEP provides all the equipment required for IV drug use.
Inmates tendency to share needles and use unsanitary equipment diminishes.
In so far as the NEP is supplemented by other health promotion and lifestyle programs.
Risk of transmission of contagious diseases related to IV drug use among inmates is reduced.
As long as staff see exchange as health promotion and not just dispensation.
As long as staff are competent health educators.
As long as staff have the time and motivation.
Inmates receive prevention and health education information
As long as inmates consider source (health promotion agent) reliable.
As long as professionals are capable of vercoming rigid and specific thought patterns (commonplaces, stereotypes,etc.)
Inmates have more information about IV drug use related high risk behavior.
As long as inmates have access to a stable team of professionals who
Provide positive reinforcement to support inmates'
Assist inmates in making information significant.
Do not combine their therapeutic role with management or
Inmates acquire healthier habits and behavior.
If inmates have external motivation (family, etc.) or a life project (motherhood, etc.).
And/or inmates are busy with other activities.
And/or inmates have positive correctional expectations.
which facilitates
Changes in route of drug use
Enrollment in drug-free treatment programs.
Enrollment in methadone treatment programs.
producing
which leads to
Improved quality and life expectancy for drug-addicted inmates who are unable to quit.
Sougt outcome
Intermediate Results
General Premise
Emerging Premise
Recursive Premise

As a result of this work, the evaluation was nourished with the two virtues that are described as part of the theory-based method[13] (Birckermayer & Weiss, 2000, página 409):

- **Advantages for planning the evaluation:** Elements that were worthy of special attention during the evaluation process were identified (What do we want to explore in this evaluation? What questions are we trying to answer?) , and a "travel plan" was designed in order to guide the data exploration and gathering about the circumstances that could affect the implementation of the program.
- **Advantages for program strategic revisions:** A benchmark was found in order to revise the internal logic of the NEP (Does everybody have the same understanding of the NEP?) and, consequently, a starting point was defined for the strategic revision of the theoretical framework as well as its design.

The evaluation questions (What do we want to explore in this evaluation? What questions are we trying to answer?), that came out of this program were classified and made operative in the evaluation matrices, which can be found in the annexes of this result report (see Annex 1).

Session 2 (February 16th, 2010) **:** Group work to systematize the evaluation questions which came up, defining the indicators that were supposed to contribute to answer them and to plan the necessary field work to generate the pertinent information.

3.3. Field work

In order to answer the evaluation questions and to explore the NEP both from the point of view of the expected results and from the factors and circumstances that conditioned its functioning, it was considered necessary to triangulate information from different sources.

To answer the questions related to the expected results from the NEP (Does successful NEP deployment and implementation in correctional institutions have a positive impact on life expectancy and quality of life among drug-addicted inmates?), the impact evaluations on the NEP prison programs around the world, were revised as well as descriptive statistics from the prison services and the rehabilitation programs (describing healthcare and addiction services) and the indicators that pointed to the heart of the matter of the prison NEP (see Annex 2).

To answer the questions regarding factors that impact NEP operation, (What facilitates and what hinders successful NEP operation in a prison?), it was necessary to identify the procedures related to the program (program awareness, access criteria, schedules, dispensation, etc.), and their potential positive aspects and limitations.

To understand why the procedures are understood (and implemented) in diverse ways in prisons, it was necessary to investigate the meanings given (by staff and by participants) to issues like drug use, harm reduction and to the prison context.

When putting together one thing with the other[14], it has allowed us to connect specific procedures with certain ways of understanding the reality of "drug use in prisons", and it has

[13] The authors attribute a third advantage related with the "knowledge creation". They suggest that the application of the model gives a body of knowledge that, with time, could contribute to concretize narrative and good practices related to the mechanisms that promote change in a determined direction.

[14] The repercussions of this methodological focus are those of any qualitative approach. That is to say, they inform us of the different meanings (narratives) that can be found in prisons related to issues like

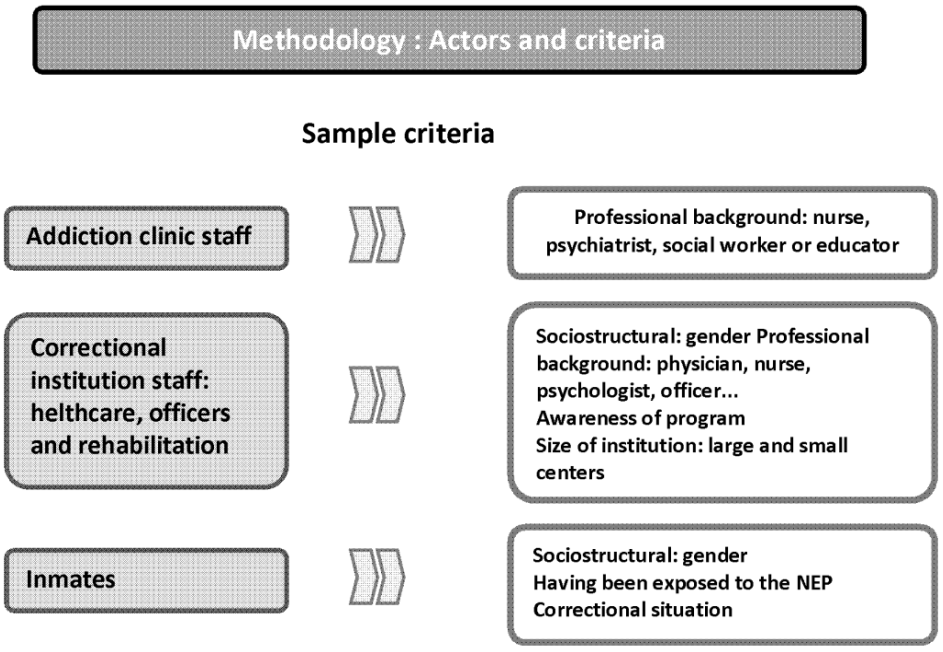
established the basis on which to build a strategy of change oriented to improving the NEP (see section 5).

Concretely, the information that came out of the individual and group interviews was looked at. Five individual interviews to key informants, 8 group interviews, individual interviews with inmates and 5 interviews with ex-inmates were done (see the list of interviews done in annex 3).

The objective of the interviews was: a) to get a better view of the theoretical logic of the program; b) to describe the criteria and procedures related o the access of inmates to the program; c) to describe the procedures used to contact drug users, d) to identify the aspects that either helped or hindered the implementation of the program and e) to identify the problems and the proposals to improve the program.

The agents that participated in the program evaluation were health professionals, treatment and security staff, and prison inmates and ex-inmates that had had contact with the NEP.

A representative international theoretical bibliographical search was done[15], keeping in mind all the sample criteria that were established and specified by the bibliography and information from the key informants. The following table reflects the criteria used.



With the combination of these criteria, 5 informant profiles were established:

harm reduction and drug use, and how these are related to certain practices (that may be more or less convenient for NEP operation). Yet, they do not inform us of neither the frequency in which these narratives repeat themselves nor their distribution amongst the population (staff vs. inmates) in the Catalan prisons.

[15] This type of search included a selection of cases based on a specific focus instead of chance and it had, as an aim, to include the máximum number of variables of situations regarding the objectives that wanted to be looked at.

- Key informants (people who, because of their professional history and/or because of the position they have in the prison, have a deep knowledge).
- Professionals in the Drug Treatment and Services Centers (CAS) who work with drug addicts in the Brians 1 and 2 prison centers.
- Health professionals who give health services to inmates.
- Security staff in the prisons.
- Treatment and rehabilitation staff in the prisons.
- Inmates and ex-inmates.

The techniques for data production that were used in this evaluation were:

- Exploratory interviews.
- Group interviews.
- Individual interviews.

The field work took place from February to May 2010. The total number of participants in the evaluation was 66. The following chart reflects the type of participants according the technique used to generate information.

Table 1: Number of informants who participated in the NEP evaluation.

Metodology: Participants

	Key informants	Addiction clinic staff	Health professionals	Prison officers	Treatment professionals	Inmates
Exploratory interviews	5					
Group interviews		2	4	1	1	
Individual interviews						13
Total participants	7	13	20	6	7	13
Total number of participants: 66						

In relation to the **data analysis**, two types were used: Theme-Category Content Analysis (AC-ct) and Narrative Analysis.

On the one hand, AC-ct allowed to have a condensed view of the information, transforming “raw data” to “useful data” through a fragmentation of the texts and establishing units (categories) with a relevant semantic meaning relevant to the objectives of the evaluation.

On the other hand, the Narrative Analysis allowed to pick out the heterogeneity of the meanings that participants gave issues like drug use in prisons or harm reduction, as well as including the opinions of the professionals and the interns in the NEP evaluation.

4. Evaluation results

The results of a theory-based evaluation give information on the theoretical assumptions held by the programs, and their relationship in the chain of hypothesis that "theoretically" should lead to the expected results.

To deal with this duplication of results, it is very useful the distinction that was established by Suchman amongst the so-called "theoretical defects" and "implementation defects" (Suchman, 1967).

The "theoretical defects" refer to the difficulties which the program has to reach its desired results, through a logical sequence of premises and hypothesis which the program has ("*Theory failure*"). In another words, it points to the idea that **theoretical logic** that the program holds is mistaken and so the sequence of causes and foreseen effects, basically, is not solid enough.

> This line of thought would, in our case, lead us to question if "giving inmates needles" actually produces "improvements in their quality of life".

The "implementation defects" refer to the difficulties which the program can run into to put into action the processes, devices, resources of activities that (theoretically) have to lead to the expected results (*implementation failure*).

The work done on the **implementation logic** can help to see if the processes and mechanisms of the NEP have been adequate, if they have occurred in the foreseen manner and, especially, if it has helped to interpret the reasons that have helped or hindered the success of the theoretical logic.

> This line of thought would, in our case, lead us to ask if "NEP implementation" has actually taken place "as planned" and to what extent.

4.1. The theoretical logic of the NEP: Are there defects in the theory?

The starting point of the NEPs is acknowledging that, as has been presented by the various European studies (H Stöver & J Nelles, 2003), one of the main health problems in the prison population is related to the use of injected drugs.

For example, in Catalonia, in 2006, 35% of new inmates in the Catalan prisons were (o had been) injecting drug users, and 50% of the injecting drug users who had HIV, has been in prison.

As we gave seen, the NEP theoretical logic takes for granted that giving clear needles to inmates will better their quality of life in that it will avoid risky practices associated with the transmission of infectious diseases (through shared needle use).

This theoretical logic is the one behind all the needle exchange programs (NEP) in prisons since 1994, when the first evaluated harm reduction program was set up in the women's prison in Hindlebank (Switzerland), which included needle dispensing machines for needle exchange[16]. Although the conclusions to which those responsible for that new pilot project were limited by specific conditions (small women's prison), we must say that the theoretical logic that fuelled the project showed to be consistent. Used needle sharing was practically eradicated between the women inmates and the tests done later on when the program was implanted showed that no woman inmate had been infected with HIV nor Hepatitis during the implantation period (J Nelles, HP Hirsbrunner & TW Harding, 1998).

Since then until now, there have been various initiatives that have contributed to create evidence related to the logic which fuels the needle exchange programs. The favorable arguments in support of the creation of NEPs in prisons are based on their potential to reduce the transmission of infectious diseases through injection (R Jüngens, 1996) and their effectiveness in a non-prison setting (J Nelles, Vincenz, Fuhere & HP Hirsbrunner, 1999). The arguments that have been put forward against, are related to the hypothetical increase of the drug use which the NEP might entail as well as the potential harmful uses of syringes and needles (aggressions, etc).

In the late 1990s, the debate around the logic of the NEPs in prisons was illustrated in what Hughes wrote in 2000:

> *"(There are authors who say) that the low and stable levels of infection in the New Wales prisons (Australia) are due to the success of the interventions of the prison staff (and not due to the hypothetical needle exchange programs) (Eyland 1996, p.59). Yet, other authors (Doland et al. 1996b) argue that these low levels of infection are due to the prevention measures that take place in the non-prison milieu and not so much from the efforts that are being done in the prisons. Mahon (1997,p.2) develops the argument that the absence of harm reduction programs in the prisons cause a comparative harm which, at the same time, weakens the community-based programs".*
>
> (Hughes, 2000)

In the year 2002, a thorough bibliographical review regarding the prison needle exchange programs explored these types of initiatives in prisons in Switzerland, Germany and Spain (Dolan, Rutter & Wodak, 2003).

Of these initiatives, six were evaluated and all of them confirmed the logic behind the program: its deployment resulted in a drastic reduction in risk behavior (sharing needles) as well as lower rates of transmission of HIV, Hepatitis B or C.

Although each prison had its own unique defining traits[17], and so there were different ways that the NEP could be improved, the general conclusions of the evaluations was, nevertheless,

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[16] It is important to point out that the first needle exchange program in prisons was set up in 1992 as the result of a personal initiative by Franz Probst, in the Swiss prison of Oberschöngrün. After a few months of its functioning, the initiative was recognized and legitimized by the relevant organism, and that inspired the first NEP pilot project in the Swiss prison of Hindlebank (J Nelles & T Harding, 1995).

[17] Each prison's characteristics were different (organization, level of security, etc), as well as the ways in which dispensation took place. Some centers gave out needles through their health staff, while others had outside staff and others used dispensing machines.

favorable in all sites. They reported a stabilisation or reduction of the levels of drug use in the prison, a decrease of needle-sharing and a decrease in HIV and Hepatitis C transmission.

While it is true that the evaluations that this analysis refers to took place in relatively small prisons (which suggests that there is a need to evaluate NEPs in larger prisons before confirming their viability), there were various studies which, having examined the risk level and the level of infections, had for some time been recommending, the deployment of NEPs in prisons in France (Rotily et al., 1994), Australia (Dolan, Wodak, Hall, Gaughwin, & Rae), Canada (Dufour et al., 1996) and Greece (Malliori et al., 1998)[18].

When it comes to Spain, the NEP evaluations in the Bilbao prison (Menoyo, Zulaica & Parras, 2000) or in the Pamplona prison (Villanueva 2002), put in evidence that NEPs were adaptable for prisons, that they did not involve a significant increase in drug use and that they were related to a decrease in risk practices (sharing and reusing needles), less abscesses and unhygienic injection, less overdoses and less cases of HIV and Hepatitis B and C.

Later on, in 2004, the first report of the Canadian HIV/AIDS Legal Network was made public. Drawing on evidence generated in NEPs in Switzerland, Germany, Spain, Moldavia, Kyrgyzstan and Bielorussia, this report confirmed the good results seen in past evaluations (Lines et al., 2006).

Along the same lines, in 2006, the Public Health Agency of Canada (PHAC) presented a thorough study focused on giving scientific, medical and technical assessment on the efficiency and the possible adverse results of the NEPs in prisons from a public health point of view (Public Health Agency of Canada, 2006).

As was published by Chu and Elliot (Sandra Ka Hon Chu & Richard Elliott, 2009), the conclusions from these latest studies have contributed to validate the theoretical logic of the NEPs in prison, by stating the following:

1. The NEPs contribute to reducing the use of dirty needles and as a result of this, it reduces the transmission of IV infections.
2. The NEPs facilitate the contact of drug users with drug treatment programs.
3. The NEPs contribute to decrease the health interventions related to abscesses.
4. The NEPs contribute to diminish the number of interventions related to overdoses and death from overdoses.

And also, when it comes to institutional security, it has been shown that NEPs in prisons do not encourage:

1. The use of needles as a weapon.
2. An increase of violence in the institution.
3. An increase in the requisition of illegal drugs or related material.
4. An increase of drug use.
5. An increase by inmates in the use of injected drugs.

All the data gathered up to now (describing the impact NEPs have on correctional institutions), has allowed us to make two types of decisions.

[18] By 2005, there were NEPs in prisons of different sizes and levels of security in countries like Switzerland, Germany, Spain, Moldavia, Kyrgyztan, Belorussia, Armenia, Luxembourg, Romania, Portugal and Iran.

Firstly, it supports the benefits associated with the correct implantation of NEPs in Catalan prisons with a positive effect on the quality and life expectancy of the drug using inmates.

In this way, an analysis of the data collected by both the Department of Justice as well as by the prisons themselves, has put in evidence that the introduction of NEPs in the prisons has not interfered with the decrease in the principal health problems of the last 10 years (year-on-year changes in number of reported AIDS cases, point prevalence of HIV and prevalence of hepatitis C). In the same way, the introduction of the NEPs in the prisons has not resulted in an increase in neither assaults on staff nor in overdoses (see data in annex 2).

Secondly, it has moved the emphasis of the evaluation beyond the impact measures. The large body of evidence that exists in relation to the theoretical consistency of the NEPs, has allowed us to focus our evaluation of the program on exploring the circumstances that condition the correct functioning of them in the prisons (implementation theory).

4.2. The pragmatic logic of the NEPs: Are there mistakes in the implementation?

Between 2005 and 2010, the global indicators of participation in NEPs put in evidence that, amongst the inmates who have a past of injection drug use, only 2.4% have participated in the program (see annex 2, chart 3).

Although it is true that not all the inmates with a history of drug use continue using drugs in prison, the results of the evaluation show that those who do not have a history of drug use or those who are in the methadone maintenance program, do not necessarily abstain from using drugs.

Faced with this, it is neither easy to quantify the potential population users of the NEPs in prisons (who uses injected drugs in prison?), nor is it easy to figure out the relevance of the percentages of participation.

Despite all this, both the low levels of participation as well as other indicators[19] suggested by the different processes of the NEPs in prisons, could make one think that the results of the program have been influenced by various circumstances in its "implementation".

[19] Some of the indicators are suggested by:

The uneven evolutions in the levels of participation in the NEPs. While there are prisons in which the participation has been drastically reduced in the past 5 years (although the number of inmates with a history of drug use has been the same), in others (of similar characteristics) the participation has stayed in percentages more or less significant.

The uneven annual ratios of user-needle. There are prisons where the ratio has been 4 needles a year per participant and in the following two years it has shot up to 24. In other prisons, the average ratio has been of 12 needles a year, and in others, it has been stable at 5 needles a year.

The big differences in participation in the NEPs between prisons, when we look at the date for the past 5 years. While there are prisons in which the average percentage of participation (amongst inmates with a history of injecting drug use) is around 13 or 14%, in other prisons is barely 1%.

There are many factors that could explain these differences. Some could be due to circumstances not directly related to the NEP (more or less problems to get drugs into the prison, the level of difficulty to use drugs in that prison, etc), yet others could be related to the program itself (more access or difficulties to access the NEP, etc).

Next, we put together the results obtained after exploring, with much detail, the circumstances (processes, mechanisms, resources, etc) that the theory of change of the NEP considers necessary for the good functioning of the program.

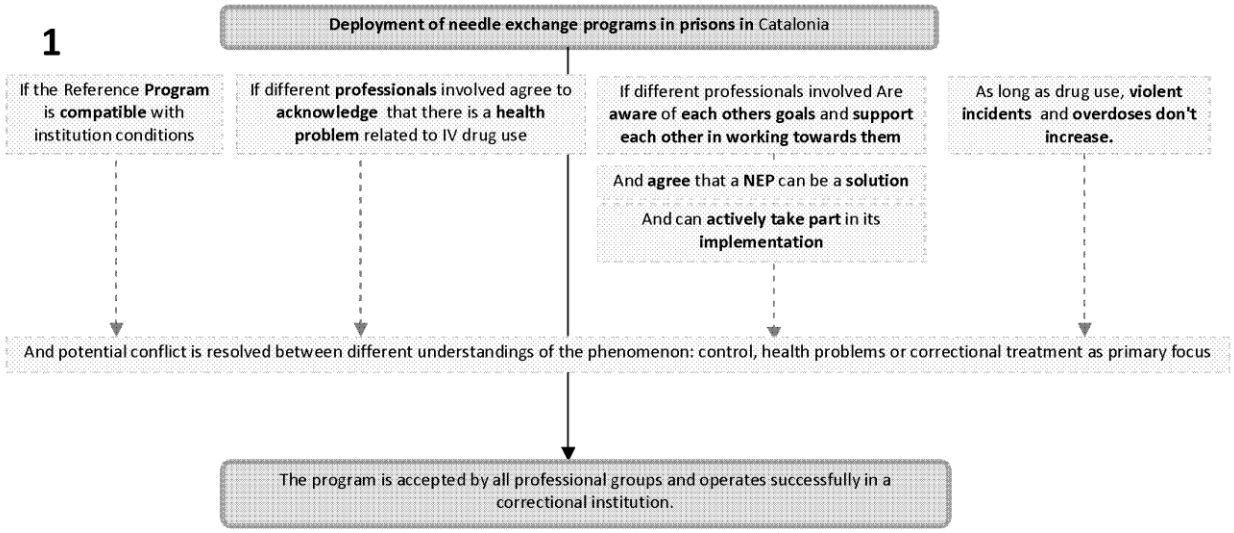
The results are organized by sections that make up the Change Theory of the NEPs:

1. First section: Adaptation of the NEP to the prison conditions; awareness of the health problem; acceptance of the NEP.
2. Second section: Give information on the NEP; NEP access criteria; program confidentiality; who will participate in the NEP?
3. Third section: Organizing the NEP.
4. Fourth section: Continuity in the NEP, the therapeutic bond.
5. Fifth section: Health education in the NEP.

4.2.1. First section of the NEP Change Theory

In relation to the first section of the contents of the Change Theory of the NEPs (see chart 1).

Chart 1



NEP adjustment to CI conditions

The NEP is a program that has been introduced progressively in the Catalan prisons and, always, under the attentive eye of the different groups involved.

This has resulted in a slow implementation that, in the majority of cases, has involved the adaptation of the program to each prison's conditions.

It has been the job of the evaluation to bring out these factors, to determine to which extent they might be related to the implementation of the program and, as a consequence, limit the positive effects associated with the good functioning of the NEP.

Yet, the evaluation has helped us understand that "the conditions in the prison" has many meanings. That is to say, that beyond the issue of infrastructures, it might be useful to consider as part of the "conditions in the prison" other aspects like each team's background, the availability of human resources, or the predominant logic of the organisms that govern the prison.

In this sense, the evaluation has shown that there is a certain amount of variability. In fact, there are attitudes which are more or less helpful in the teams that run each prison.

Some of the literal expressions that can help us illustrate these narratives are:

> *"P1: in Prison 2, the director's office gave a lot of support, they facilitated things a lot, both the director as well as the medical sub-directors, the treatment one, the interior one, the services coordinators* ***got involved a lot"***
>
> (GI1)

> *"P1: …the director's office in our prison tells us* ***we have a NEP but don't offer it to anyone.*** *If they come, we will accept them, but don't offer it".*
>
> (GI4)

Also, the fact that there are attitudes on the part of the security guards that are more or less helpful, is admitted:

> *"P1:…but at that meeting in Prison 2, the prison workers did not show us, so* ***a meeting was held****, a presentation to inform the prison workers and basically,* ***nobody came"***
>
> (GI1)

> *"There was also treatment staff that said yes, and also the security guards.* ***They said that it was about time and there was part of the bunch that had signed up".***
>
> (GI2)

And the same thing happened amongst the treatment and health staff:

> *"At least* ***it guarantees*** *that the person who has the need to inject will do so in conditions that will not add more problems, what I mean is that if he has already injected himself and has used drugs, he will have time while in prison to have the rehab staff intervene".*
>
> (GI7)

> *"P3: I think that the prison health staff (…) are* ***the first ones who should embrace this".***
>
> *"P1: Yes,* ***there is a bit of the attitude that this is not my thing (…)"***
>
> (*GI1)*

Basically, the information generated suggests that the conditions of the centers have not always been the most favorable for the implantation of a program of this type.

> *"P2: it was like a hot potato, no,* ***no one wanted the NEP"***
>
> (GI7)

Faced with this, given that the adaptation of the NEPs to the different conditions of each prison has been an unavoidable step for its implantation, at times, the fact that the logic was not the

other way (the adaptation of the prisons to the NEP) has hurt the good functioning of the program.

> *"Nowadays, **there are as many NEPs as there are prisons**, because each one does it their way".*
>
> (Field notes)

Acknowledging a health problem

Regarding the second branch of Chart 1, the evaluation results have revealed that the different professional groups recognize the health problems as a consequence of needle-sharing.

We all know that the use of injected drugs in prison is related to risk behaviors which involve the transmission of serious infectious diseases.

> *"We know that **there are people who inject themselves,** who build syringes and needles out of anything, **that they share these** and that they get infected and it is necessary to avoid this transmission".*
>
> (GI2)

Yet, when it comes to looking at the extent of the phenomenon (IV drug use in prisons), the narrative of the participants show that there are different ways of relating to it.

In fact, the analysis has put in evidence that the way that people (professionals and inmates) relate to the NEP has a lot to do with how these people see drug use, rehabilitation, health and harm reduction.

With the aim of simplifying and of clarifying the understanding of this phenomenon, we have categorized these differences around three different ways of organizing thoughts regarding these issues.

These different ways represent three paradigmatic groups (stereotypes) of different ways of doing things. In fact, they illustrate three different ways of understanding and prioritizing (by those involved in the program) concepts such as health, drug use and harm reduction.

It has been inductively built (from "the bottom up") based on an analysis of content of the information gathered and, obviously, they constitute theoretical representations (abstract) that do not have as an aim to describe closed categories amongst which to distribute those involved in the program.

People's identity is made up of a complex mixture of circumstances that are impossible to describe under one single category. People make decisions based on many factors and, as these change, so changes our perception of the world.

Despite this, we are making this proposal with the aim of describing three different ways of looking at injected drugs in prisons that, although are the result of simplification, have helped to review the NEP from an evaluation point of view.

A.- There is a first group of people who, when asked about "drug use in prison", tended to build a narrative in which the central element was **"the transmission of infectious diseases".**

When a person talks from this point of view, he shows that for him or her, the most problematic aspect of drug use in prison has to do with *"the associated risks of sharing needles"*. Around this idea other issues place themselves (explain themselves) such as drug use, rules and regulations, the NEPs, braking rules, treatment, amongst others, but at the centre of the narration there is the problematic issue of the transmission of infectious diseases.

B.- Yet, other people, when asked about "the use of injected drug used in prisons" tend to build a narrative around **"drug use**" itself. The most problematic aspect in their narrative tends to be "that inmates use drugs" and it is around this that other issues place themselves like sharing needles, norms, the NEPs, etc.

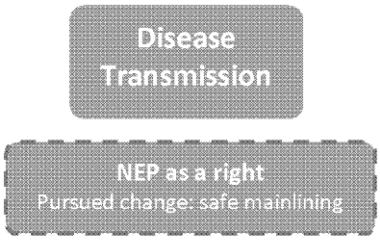
C.- Finally, there are others who build the problem around **"the autonomy of the inmate to use drugs"**. The central idea of this narrative is seeing as a problem that inmates may have autonomy to freely access needles. The autonomy is an element which brings up as problems other issues like drug use, sharing needles, norms, etc.

This distinction colors all the results that are described next. In fact, the next steps in the Change Theory are explained in one manner or in another depending on which is the central idea on which the narrative of the person who is speaking is built.

NEP acceptance

The results of the evaluation have underlined that those who build their narrative around the central issue of **"transmission of infectious diseases"**, tend to accept the program without reservations. They call on the idea of "the right to health" over other considerations (such as that "drug use is bad for one's health"). The program is accepted because all the inmates have a right to it (no other conditions are necessary).

> *"It is a right that a person has besides it having a specific objective, it is like one more right that the person has, like the right to eat,* ***so he also has the right to inject himself with a clean needle"***
>
> (GI1)

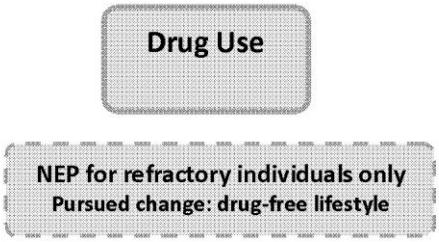


Those who build the narrative around the issue of **"drug use**" tend to accept the program but with some reservations. Because the centre of the reasoning is "drug use", the emphasis is placed here. The program is accepted because "if drug use cannot be avoided, then it is better that it be done safely".

> *"****So, if there are no other options****, you are a candidate for the NEP and you have whatever you want, but we do it* ***because there is no other option with you****, right?*
>
> (GI6)

"P4: ***First, he should go into a methadone program*** *or another medical treatment program* ***before he injects himself****, but if his craving is such and he says that he needs to inject himself, well then, you let him go to the exchange program."*

(GI4)



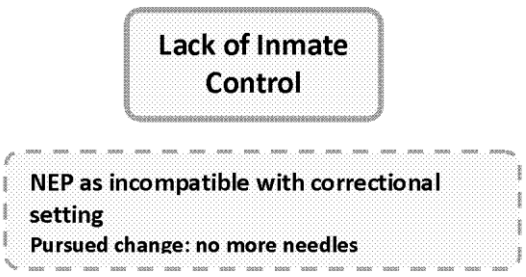
Those who build their narrative around the issue of **"the autonomy of the intern"**, do not tend to accept the program as such nor how it is conceived. At the centre of their reasoning there is **a concern with control.** As a result, they are narratives that underline that a prison is a disciplinary context, where the autonomy of the intern must be limited. To the extent in which the NEP appeals to the autonomy of the intern, the acceptance of the program is seen as being compromised and, even, incompatible with a prison.

"I cannot accept the program because ***before we had drug use under control and now we don't know what is going on".***

(Field notes)

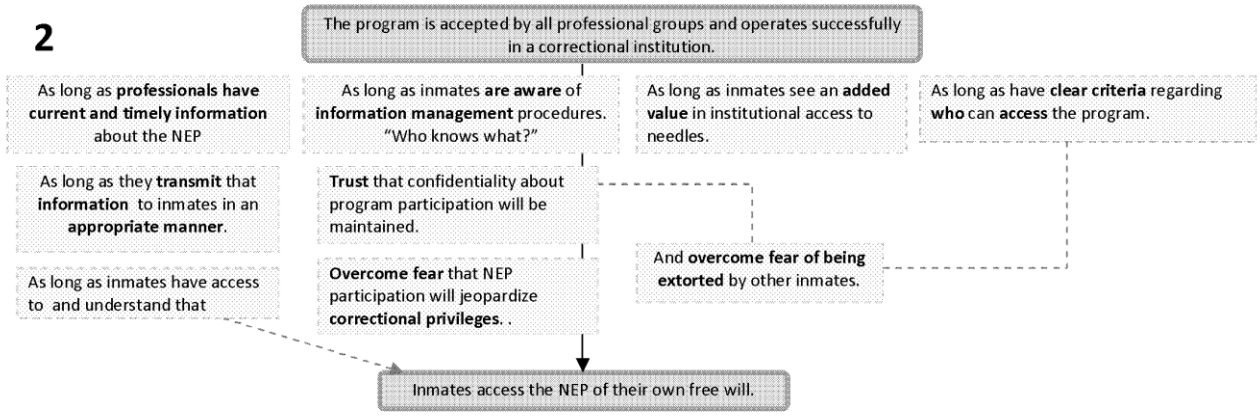
"The NEP ***is totally absurd, it makes no sense to give him something which is banned****, so supposing a kleptomaniac comes into the prison and so you have to let him rob, because he is a kleptomaniac, so a heroine addict comes in, okay, you can get rehabbed but don't give him more opportunities to drug himself".*

(GI3)



4.2.2. Second section of NEP Change Theory

Now we present the results we have obtained analyzing the sequence of premises and expected results of the second section of the NEP Change Theory (Chart 2)



Providing information about the NEP

The NEP is a program that the way it is conceptualized, it gives a major role to health professionals. As it is thought out in Change Theory, it is necessary that health professionals be informed (and that they also inform) of the existence of the program, as well as authorizing and monitoring the participation of inmates.

All the professionals with whom we have contacted knew of the program but, as in the section above, the orientation that they showed regarding the program varied depending on their conceptual starting point.

On the one hand, when the narrative centers itself on the concern about **"the transmission of infectious diseases",** then transfer of information to inmates becomes a key aspect for their enrollment in the program. So participants put the emphasis on using all the available means to inform of the program to all potential users, through direct contact or through posters.

> *"I mean it, it is important **that you explain to them from the beginning and that they know that there is an NEP".***
>
> (GI4)

On the other hand, when the center of the narrative is the concern with **"the use of drugs**", the information is more of a reactive type. The starting point is the idea that the inmate is already informed of the program because they exist in the community and in other prisons. In the case in which the inmate may be interested, it is taken for granted that he will ask for the information necessary on how to access it.

> "*People **already have the information**, they know from the community. If a person wants a needle, they go and they ask to go into the program and then we go and interview them".*
>
> (GI6)

NEP access criteria

When the participants in the evaluation centre their narrative on the concern for "**transmission of infectious diseases",** the program takes the form of an unconditional service. There are no

questions asked and no conditions are posed. The access to needles is without any exceptions[20].

"The only condition is that ***you want to inject yourself, you don't want to get infected, so here is the needle".***

(GI1)

This narrative projects gives the responsibility to the inmate. It does not judge whether drug use is good or not. The only behavior it tries to modify is the way that drugs are used but not the drug use itself.

From this point of view, and within the limits allowed by the prison, it is considered that an inmate is a subject that is responsible for his or her own actions. It takes for granted that the inmate makes the decision of using drugs and the right to use drugs safely is given importance. The values of the professional do not interfere with access to the program.

"The only thing you are doing is giving a needle to try to stop the transmission of infections, *the fact that he can die from shooting up that can happen whether the needle is dirty or clean, that is the same".*

(GI6)

Yet, when the narrative is around the concern of "drug use", the accessibility to the program is affected. Concretely, two conditioning factors emerged that usually restrict access to participation in the NEP.

First of all, there is the concept of the NEP as a resource of a process which has stopping the use of injected drugs as a final objective. In another words, the NEP is understood as a last resource: If the inmate has not been willing to try other options, then the professional gives him a needle.

"P4: No, before they enter into the program, ***you talk about the problems of drug use.*** *P3: We also say to them: it is* ***better if you change how you use drugs, why don't we increase your methadone?"***

(GI6)

"*I see it as a last resort".*

(GI5)

This way of working has conditioned the access to the NEP to the extent that, in most cases, it has not met inmate's expectations:

"***I think that they create a lot of obstacles.*** *They should assess people more, so that they will be more aware, although people too make mistakes".*

(GI3)

Secondly, besides being seen as a last resort, it is also common that the values that are predominant in a certain team of professionals have colored the implementation of the NEP. In this sense, we could pretty much say that there are as many "types of NEPs" as there are "types of teams".

[20] The only exceptions described are when the petition for a needle has come from a pregnant inmate.

In another words, the conditions for access to the program have not been the same everywhere. The access has been conditioned by the opinion that the teams have of the decision that the inmate has made to use drugs, taking into consideration the inmate's behavior in the past and in the present. If it is considered acceptable because it is an old addiction, then a needle is given.

> *"P4:* ***they show you if they have injected in their arms,*** *I mean, we look a bit their basic record and if they have disciplinary problems, well, I mean, we assess what type of inmate we are faced with"*
>
> (GI6)

> "*Those who ask for needles for someone else, they are not accepted into the program, and those who have a record of mutinies or shit like that and do not have a clear history of using drugs* ***we do not give them needles either"***
>
> (GI6)

> "*We are going to observe you for 15 days before we give you a needle".*
>
> (II2)

Yet, if the professional feels that the decision is not acceptable because, for example, the inmate is in a methadone program,

> ***"I am not giving you a needle if you are on methadone,*** *I don't think it is good to consume and I am not giving you a needle. Before we give out a needle, we try to get the inmate to go into the methadone program, we talk with him".*
>
> (GI6)

or because he had dangerous precedents,

> *"If a person wants a needle, (…) we go and interview them, and in the interview we talk with him,* ***we look at his criminal record and specially his behavior in the prison"***
>
> (GI6)

or because he had not used drugs before,

> ***"If you have never used drugs, you are going to have to convince me,*** *and if you convince me, I will give it to you, I don't have a problem, but the problem is that it is a needle, I cannot give it to you just because you would like to have it, because I am forced to control it"*
>
> (GI6)

it could work itself out by not giving out a needle with the aim of avoiding drug use.

> ***"****So* ***there is a certain quantity of people who are not allowed to come into the program*** *because they were not heroine users, so no, nor were they cocaine users so it did not make any sense for him to have a needle"*
>
> (GI6)

Or the access to the program has been conditioned by the inmates who, for example, those who agreed to attend workshops on health education.

"(…)Yes, good, I get it, I respect that you might ***want to enter into the NEP but in exchange you will have to go into the health education program****, okay? It means going certain amount of hours, you have to come to an agreement with the educators"*

(GI6)

So, all together, and according to what the inmates who participated in the evaluation of the program, this way of looking at the NEP does not encourage their participation in the program. Basically because they have been involved in problematic situations from which they prefer to keep a distance:

"I'd rather have my own needle hidden somewhere and shoot up whenever I want to, ***with no one controlling me,*** *no one in the prison, no professional"*

(II6)

A side effect of this way of seeing harm reduction in general and the NEP in particular is related with the process of taking responsibility away from the inmate which take place in the prisons and which affect the good working of the NEP.

Firstly, because the decision to use a clean needle is not in the hands of the inmate but in the hands of a professional who, sometimes, feels responsible for the consequences derived from the use of a needle.

"P3: What I see mainly is that we are the keepers of health. In prison ***the ones who have the most responsibility is us.*** *What I mean is that we are giving out something (a needle) that has not been prescribed, because it is not a prescription".*

(GI5)

"So you give this guy a needle and he has an overdose and a family member says: hey, my son went into the prison alive and he comes out dead and you gave him a needle with which he has died. ***We have the responsibility for their health"***

(GI5)

"Here, when a person dies, it is investigated. ***So for the doctor it is a hard experience".***

(GI2)

In fact, when the main concern of the professionals is "**drug use**", these tend to describe themselves as the ones responsible for the consequences derived from the use of the needle, and as a consequence of that, there is the fear of legal repercussions that also condition access to the NEP:

"It is the fear, (…) that if one day there is a trial, they could ***take away your license****, we are afraid of someone dying"*

(GI1)

Secondly, because when the inmates lose their capacity to decide about their own health, they stop feeling like they own their health. Their health stops being something which they feel they need to protect and it become something that the institution has to protect. When this happens, health becomes a bargaining element which colors the relationships between professionals and inmates and gets in the way of health services in the prisons.

*"P6: In prison we feed them, we let the watch television, we give them clothing, we give the medication and he is not responsible for anything****, so he plays with the weapon he***

has, which is his body, *which is the weapon of aggression and defense which he has in a hostile environment. So when the inmate wants to cause trouble…he hurts himself".*

(GI5)

Probably, a factor that has contributed, to a large extent, to consolidate this type of dynamic has been the global logic of the prisons. In this way, in a context in which the inmate is responsibility of the prison, where the autonomy of the inmate when it comes to making a decision about their own health is restricted, and where it is hard to ask the inmate to be responsible for his own health, it is not strange that a certain process of losing responsibility occurs amongst the inmates [21].

"The prison milieu (…) falls into the trap of ***making them dependent*** *to such an extent that everything the inmate does ends up being* ***the responsibility of the institution****, (…) and the institution does not give the individual the space and the means to* ***build his or her skills to be autonomous and decide*** *(…), we act like their daddies and mommies and we take responsibility for absolutely everything"*

(GI5)

Basically, the process of taking away people's responsibility condition the health services in general and the implementation of the NEP in particular.

Program confidentiality

The NEP Change Theory says that for the program to work well it is necessary for there to be a high level of confidentiality.

When, at the center of the narrative there is the concern about **"the transmission of infectious diseases"**, confidentiality becomes a necessary prerequisite as well as anonymous participation, which can be translated into not using written registries, not giving notifications, or giving more than one needle to an inmate so that he or she can give it to whoever else might need it, etc.

"I wish we could give two needles to an inmate, *he might sell it, I don't know, but he could also give it to another person if necessary."*

(GI1)

At the moment, the only way of participating in the NEP anonymously is to do it in a clandestine manner. That is to say, accessing the needles of the NEP through another inmate who, for whatever reason, plays this role (this aspect is dealt with in part 2.4). The fact that these situations exist put in evidence that, for a certain number of inmates, being anonymous is fundamental for their participation in the NEP.

"P: Maybe an inmate ***has had problems****, right? For the simple reason that he has done needle exchange, and then, if they have commented it between them, so then* ***they would rather ask someone else to lend them a needle*** *(…)"* (II1)

[21] In fact, as it is shown in the report by the Fundación CREFAT (Ligero, 2002) and according to M. Foucault, being imprisoned involves a personal process of losing legitimacy as an adult and as a responsible person. It is thought that the way that the inmate has had to govern him or herself until now is what has made him break the law, with which, he is see by society as being irresponsible. He is seen as incompetent even for the most intimate decisions, as would be the responsibility over his or her own health.

Instead, when the narrative is centered on "**drug use**" or "**the autonomy of the interns to use drugs**", the confidentiality becomes, instead of "anonymous", a "secret"[22]. It justifies the registry and the follow-up of the participants for therapeutic reasons or for security reasons. Take a look at the following quote from a health professional:

> *"I mean, when the inmates came into the NEP, we would say to them, 'hey, don't worry, we won't tell anyone that you participate in the NEP,* ***we won't tell anyone'*** *and so on and so forth, but after a week, the prison staff knew it"*
>
> (GI6)

Or the quote from this security guard:

> *"There is a lack of information (…) I don't say that everyone should know, but those of us who are in a way coordinating a department, we should know,* ***we should have some idea*** *of who is participating in the NEP"*
>
> (GI3)

The norm, the written version of the NEP, says that the program should be able to guarantee confidentiality. The program explains that the NEP in the Catalan prisons *will be implemented by the NEP team. Their job is to gather and give out material in the schedule and the places established. The* ***confidentiality of the exchange*** *has to be guaranteed"*

Yet, the participation in the NEP is not anonymous. It is necessary to register, control and, in the case of a search, one has to say that one is in the NEP (so the confidentiality ends up spreading beyond the health care staff).

> *"According to the contract, it says that if there is a search and if the security guard asks you if you have a sharp object,* ***you have to show the needle****"*
>
> (GI1)

In closed environments, such as prisons, having confidentiality be so fragile, it results in high levels of mistrust. This is especially problematic with a program that depends on confidentiality for its functioning, as it is shown in the NEP Change Theory.

> NEP Change Theory:
> "The inmates participate in the NEP when they have and they trust in the mechanisms which have to guarantee confidentiality".

The data gathered have helped to understand why one of the main perceptions amongst the inmates and the professionals is that it is inevitable that the information on who is participating in the program ends up being known. The following quotes reflect this idea:

> *"I have never been told: 'you have so many in your module', but* ***we have always found them,*** *I believe that we do our work well"*
>
> (Security guard; GI3)

> *"(…) This is something that no one should know, who has a needle, but at the end of the day,* ***everyone knows who has a needle****"*

[22] While the concept of "anonymous" refers to a person with an unknown name, the concept of "secret" refers to a person with a known name, name that it is revealed in a reserved manner between two people (definitions from the Spanish Royal Academy of Language).

(Health professional; GI5)

*"**There is little confidentiality**. All the prison workers know that you have a needle (…) the other day I went out and one prison guard said (…) 'be careful with what you have in your pocket!' and I said 'Careful with what?' 'With you know what'".*

(Inmate; II2)

*"It is really **hard to keep confidentiality here**"*

(Health professional; GI2)

On the one hand, this deep feeling of lack of confidentiality has limited the participation of the inmates in the program, because if it was made public, it would make their daily life a lot less comfortable.

*"**Many have left the program** because they felt watched, and it is logic because if drugs a banned and you have a needle, (…)I will go after you to see if you are the one who is bringing in the drugs".*

(GI2)

*"The fact that there is no confidentiality undermines all the work you have done, right? **Because each time that a prison guard goes and sees him and says if I find a needle and it is used**…even if they are false threats, but of course, for them it is just now worth it"*

(GI1)

Some inmates have said that being in the program is equated with making drug use visible, to have problems and, to the extent that their drug use is controlled, when one needs a needle "they will have to get around the system".

On the other hand, the lack of confidentiality clashes with what seems to be an implicit pattern in prison behavior: "*the less you are noticed and the less encounters you have, the better, the less the better"* (EII3)

Inside a prison, to be low profile means being discreet with the rest of the inmates:

*"I don't care what others do with their lives, **better not to mix with others much**"*

(II4)

And it means not attracting attention in an institution, the prison, that when the person is watched the priority is to report the "bad things" that the inmates do and not "the good things"[23].

[23] In this sense, the information from the study "*Anàlisis del discurs dels usuaris de programas d'atenció a les drogodependències dins de presons" ("Narrative analysis of the inmates in drug treatment programs in prisons")* (Ligero, 2002). One of the fundamental conclusions of this study allows us to see that, in prisons, confidentiality is seen, by the inmates, as a transversal value, desired in all prison activities: "*Computer systems hurt prisons. The observation tends to highlight the negative aspects of the inmate's record, (…) the conversations with the professionals can follow a chain that ends up giving information to the Treatment Committee. Basically, the more exposure to information system, the more vulnerable is the inmate and the chances of having problems increases. (…) visibility is a trap. The information about a person ends up being used against that person. The risk of having problems make the inmates keep a distance from surveillance, looking for hidden*

"*Here also you have to learn to live, (…) the person is labeled…Once you enter the prison, you have your discipline file (…), if you are a lost bullet, you enter the prison and they classify you (…)* ***they tend to label you and put signs on people…****Because of their past…and sometimes it is hard to get out of that".*

(II4)

"I have eight points against me because I pulled out knives, but that was in the year 1990 something, in La Roca, in La Roca del Vallès, in Cuatro Caminos…And I say ***'what is going on? They will never take those points away and why?' and they say: 'no'****".*

(II2)

This situation has conditioned the access to the NEP because, for now, the fact that the institution can see the inmate as a drug user means, in most cases, that the inmate cannot benefit from the prison benefits. We must keep in mind that when a person is jailed for drug-related offences, the lack of abstinence is considered a factor that can lead to commit another offence.

Between this and with what the participants say, very few people are willing to give up prison benefits in exchange for having a needle from the NEP through the proper channels (they would rather use someone else's needle or to access the NEP in a clandestine manner).

"When people think of the future, when they think ahead, knowing that halfway through the prison term they call you to see how you are to be able to go on leave, and ***it is a bit scary to think that that (participating in the NEP) might come up".***

(II4)

"*The idea that most inmates have is that* ***they don't participate in the NEP because then they will watch you*** *and they will seen badly by the prison guards and also by the treatment staff. This is the reality we have now."*

(II2)

At this point, and even though we have gathered some narratives favorable to the coordinated work between the health and the treatment teams, it seems that from the inmates' point of view, there does not seem to exist a path that integrates harm reduction with prison benefits.

*"I am not going to lend you a needle, go ask for one", "****No, the problem is that if I ask for one, they will watch me more****…if I am in the program and such…" and I say "well, that is your problem.* ***I am also in the program****". (…)* ***but I know that I won't get to go out on leave,*** *since the 1990s I don't get to go on leave".*

(II2)

---

corners in the courtyard or in the neutral activities offered by NGOs. In another words, the inmate looks for the surveillance's blind spots".

Who takes part in NEPs?

Keeping in mind the results seen concerning needle access, the following question needs to be addressed: Who will take part in a NEP if part of an inmate's chances of progressing to a better security category requires avoiding being noticed?

> "**It's better to just hide things** … keep them from being known. When you commit an offense, you don't go down to the police to turn yourself in, you don't tell."
>
> (II8)

Judging by participants' intput, we would expect the range of potential NEP users to be, in fact, restricted to those inmates who don't yet have the possibility of accessing any kind of privilege, or have simply given up trying.

> "I think this NEP thing is fine, OK? It's good for people that are in the situation I was in the day, nothing to look forward to, years of sentence ahead, **stuck in a unit, shooting up... well, then being in a NEP did me good.**"
>
> (II5)

> "However, someone who is in a level 4 unit, planning on getting out, they may be using and using … but **they're not going to take part in a NEP because they're afraid the treatment staff will find out... and they'll end up facing a whole bunch of tests**."
>
> (II4)

This leads us to question our basic assumptions regarding the added value of institution-supplied needles. According to the theory of change that underlies NEPs, inmates will access the program *if they see an added value in institution-supplied needles*. This added value can have different sources: practical issues (convenience, less expensive, etc.) or broader issues (caring for health).

Highly fragile confidentiality and a setting where personal responsibility is particularly problematic make inmates perception of added value in NEP-provided needles difficult. Only those who don't have a better option (their own needes) or who are far from benefiting from any privileges (or have given up trying to obtain them) will enroll in a NEP.

> "Q.- You've said that if you had your own (needle) you wouldn't access (the NEP).
> A. - Right. **It saves you having to play hide-and-seek**"
>
> Later in the same interview
>
> "Q.- So, why are active users not taking part in the NEP...
> A.- **Because the have another one.**
> Q. - Simply because they have another one.
> A. - Or **because they're about to get out or … each case is different.** We're not all the same."

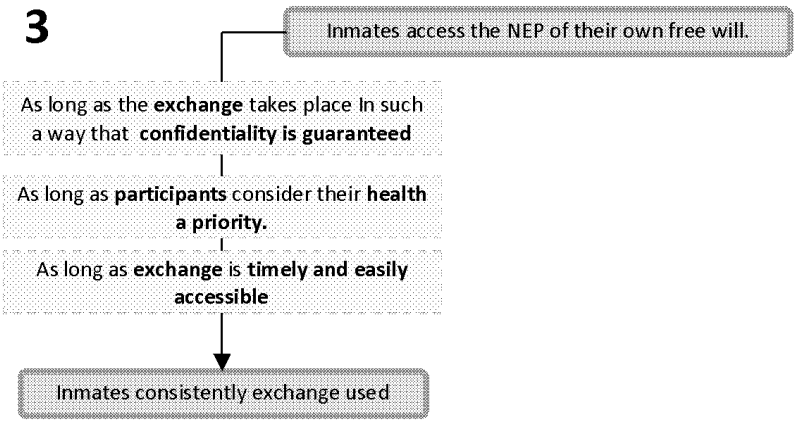
Finally,

> "I know **I have no chance of getting out, so I'm on the NEP**. I don't care if the warden … or Mr. Obama, the President of the United States finds out."
>
> (II8)

> **NEP participants never actually get that far** – being released on leave or anything like that, because they're really difficult inmates that are constantly subject to disciplinary action, so they're not motivated to do anything, but on the other hand, if they don't do anything, they can't access privileges, so it's one big wheel.
>
> (GI6)

4.2.3. Third Section of the NEP Change Theory

The results of our analysis of the third section of NEP change theory are as follows (chart 3)



Exchange organization

NEP change theory tells us that "guaranteed confidentiality" and timely and convenient access to the exchange are requirements if we are to achieve our goal. Therefore, program access (previous section) and needle exchange are key procedures to ensure NEP success.

Participant's comments reveal that when staff narratives tend to emphasize "**infectious disease transmission**", the resulting exchange organization has been kept as flexible as possible.

From this point of view an exchange's primary task is guaranteeing (as broad and inclusive as possible...) access to NEP needles. As follows from the facts determined in the previous section, this will involve making the exchange an invisible activity which matches the logic of addiction (immediacy, etc.)

> "P2: since I've been there, I never have to call on anybody. They come on their own. It's as if the office where I work **is hidden from the officers' eyes**."
>
> (GI1)

> “When a user has drugs, he wants to do them. Managing that in here, providing a needle just at the right time is complicated.”
>
> (GI2)

To maintain invisibility and provide for the specific needs involved in addiction, exchanges need to be organized keeping in mind the importance of flexible hours and a broad range of professionals, which sometimes may include staff not directly involved in healthcare.

> “**If any staff member could do it, then it wouldn't require a visit to a specific office**. It could be done in groups, in any visit to any other office and then it would be far less visible to officers, and then I think we would achieve more, but...”
>
> (GI1)

> P3: I'm a prison physician (…) my workday starts in the early afternoon. I visit unit eight. The rest of the day I deal with unit inmates who may be ill, or methadone administration or NEP. There is a nurse who, in theory, only works on the NEP. And a **counselor**, who, apart from working with new admissions, does follow up with NEP users.” (GI6)

However, inmates:

> “If you're a regular user, it's a problem because you're going to be constantly moving around …. and if it's a one-off, then chances are **you won't have access to a NEP needle right then**, because drugs get in when they get in”
>
> (II4)

but also professional staff

> “If I want to continue shooting up, I have to ask for another one. Someone has to come and give me another needle. That takes time, and **time isn't something we can count on in addiction**”
>
> (GI2)

have expressed the view that current needle exchange organization does not make NEPs an invisible activity nor does it facilitate matching the specific needs seen in addiction.

This involves the physical setting of the exchange:

> “P2: And … it's difficult. You go into a unit. You want to call an inmate to give him a needle. You have to go into the doctor's office. You have to ask for the keys. The keys are often in the officer's room. So you take the keys. But they're used to seeing you hand out methadone, but not actually going into a unit.”
>
> (GI1)

And the availability of these professionals:

“We have a problem. From 9 PM to 9 AM there a**re no health professionals on site**.”
(GI6)

And also the available hours are inadequate to ensure consistent needle exchange:

> "P3: our time for exchange is limited. In the afternoons we're not there, so there is a big, gaping hole..." (GI1)

> "I need three doses a day – or so the methadone nurse told me. But **that would involve going three times a day. There is no way I can go three times a day**." (II3)

On the other hand, professionals whose narratives reflect "drug use" as their primary concern tend to question the organization of the exchange far less. For them the exchange becomes a place to control drug use and regularly monitor issued needles.

On the one hand, the exchange is understood as a space that enables professionals to control inmates' drug use.

> "P2: users have the right to a needle, and it's **under control because professionals are involved**." (GI1)

On the other hand, the exchange is seen as a space where inadequate needle use can be spotted, putting "control" ahead of "maximum flexibility" in accessing needles.

> "You check to make sure the needle is OK... **If you have a hunch the needle is for someone else or it has been used several times... well, you need to consider...** (removal from the program)." (Field notes)

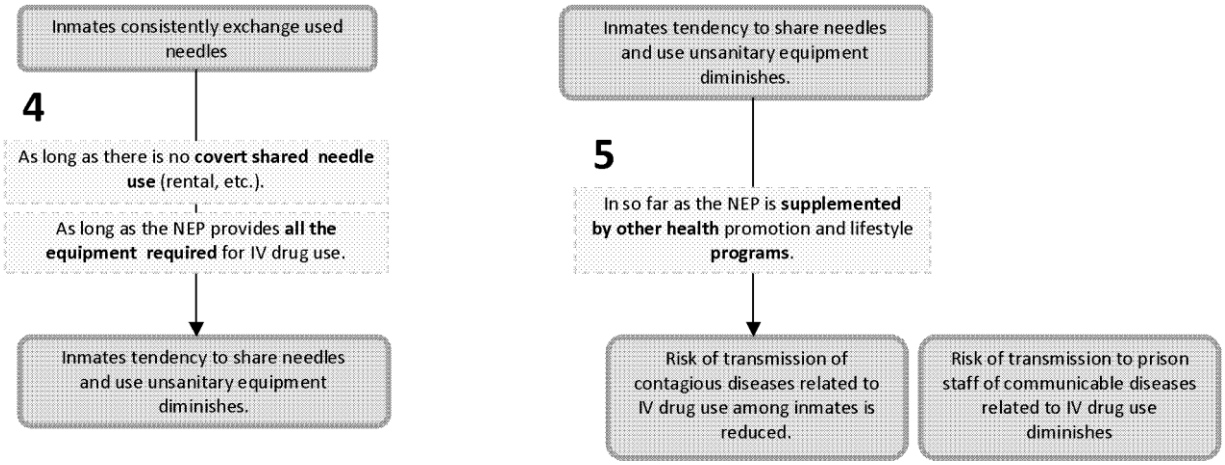
> "P3: there is a register that can prove how that person has tried to take advantage of the situation. We don't give needles out like candy bars. There has to be oversight, and that is why we don't let auxiliary staff issue them." (GI5)

Thirdly, people who structure their narrative around the problem of **"inmate autonomy"** tend to describe the exchange as a "possible space" to identify who has access to drugs in a unit.

> "I follow the guy who has the needle. **I keep an eye on the guy who has the needle, but I'm out to get whoever is selling that heroin**." (GI5)

4.2.4. Fourth and fifth sections of the NEP Change Theory

We will now present the results obtained from analyzing the series of assumptions and expected results from the fourth and fifth sections of NEP Change Theory. (chart 4).



Keeping participants in the NEP.

We've seen that access to a NEP tends to be restricted to people who don't have other better options and who are still a long way from acquiring leave and other privileges. Nonetheless, once an inmate has access to a NEP, staying in the program requires skillful management of a difficult context "in which lots of people are out to get your needle: other inmates, but officers too". The following quote is from an inmate.

> "Maybe some people **stay out of the NEP to avoid a boycott** (…) when I signed up for the program a whole bunch of people started swarming around me because they knew (…) well, **some people aren't capable of standing up for what is theirs. It's like someone smuggling drugs in, and then not being capable of defending that stash**... why bother? … you're just asking for trouble."
>
> (GI4)

In other words, participants make it quite clear that NEPs are only appropriate for people who, apart from not having much to lose, are willing and capable of successfully managing a situation that confers them with ownership of a item that is rare and highly sought-after in that context. As we pointed out in previous sections, this limits the benefits of NEPs to those inmates who:

a) Can competently deal with other inmates, who will put them under pressure to let them use that needle:

> "I: and then they sneak up to me and are like … look what I have, come on, let me use it, so on... and what can you do. I've always steered clear of any problems: no way, this is intransferable, and that's true, you sign for that needle. You promised to not share it or transfer it or you would be kicked out... **and I was very strict about that**." (GI4)
>
> "I: Lots of women aren't on the NEP, but they definitely use, so they ask you for your needle. They say, lend me your needle, and I'll give you some. **But I say no** because I don't want trouble (…) **sign up and you'll get your own**"
>
> (II9)

b) Know that they can use their status as NEP participants to access other privileges (money, free drugs, etc.)

> "I: You need to realize that **whoever has a needle, has more chances of scoring free drugs**." (II4)

6. Live in a unit with less perceived surveillance pressure, allowing them to normally participate in the program.

> "In some units there is a lot of friction with the officers... they say 'they give them to you, but we have to take them away' (…) but other units are different. Unit 1 may not have much consideration but its a calm place to live. You can live there for years and the officers don't bug you as much."
>
> (II3)

NEP rule changes.

Changing to a different subject, but that is still related to keeping participants in NEPs, reports that focus primarily on "transmission of infectious diseases" tend to point out that the strict rules set out in the NEP guidelines can be self-defeating. They feel the structure of the program should be capable of changing to address the problems that arise, making success more likely.

One example of this is one team's idea of scaling down regular participant-professional contact. The guidelines call for communication every three days. Some professionals felt this high frequency could get in the way of consistent needle exchange. Invoking this finding they have adapted their rules requiring less frequent contact, which originally did not contemplate whether or not the needle has been used.

> "So we decided to cut down on the controls, because, as we said, **those constant controls were hurting more than they helped**."
>
> (GI6)

Another example is being less strict in applying rules with inmates who have run into trouble with the prison discipline system.

> "**Many of them don't report it** (i.e. : don't inform unit officers that they have a needle) **and then if it's found we might have to exclude them from the program**, but of course, that depends on us, We'll get a report that the needle has been confiscated but **we'll give them another one**."
>
> (GI4)

Another example is provided by a source who reports telling participants how to use a needle multiple times without making additional use evident, reducing the number of exchanges.

> "P2: (…) sometimes you have to give inmates strategies, such as, after shooting up, clean the needle and put in back in its wrapper and say it hasn't been used. You have to help them pretend the needle hasn't been used." (GI1)

These statements differ from the narratives that focus on "drug use" as primary concern. In those cases, the need to control how the needle is used tends to be stressed, and following inmates up as they progress to new prison security stages.

These points of view do not consider the option of making rules more flexible to increase overall program effectiveness. Needle control is first and foremost, requiring strict rule

observance. The difficulties this may generate in terms of keeping participants in the program aren't contemplated.

> "P1: Every week, somebody isn't careful. If a needle isn't accounted for, then we can have a serious accident." (GI4)

> "P3: it's our consistent control of the needles. They don't get lost, **we always know where they are**." (GI6)

Therapeutic Bond

Finally, although it may be true that adapting NEP guidelines to the reality of each prison is necessary to ensure success, some opinions voiced the need to forge a trusting therapeutic bond with participants if we hope to keep them in the program (given the adverse conditions faced).

> "P5: And another factor that affects us in trust. If some things have worked well in this program, that has been a **result of the existence a therapeutic bond with the inmates or with program participants**."

And later in the same conversation:

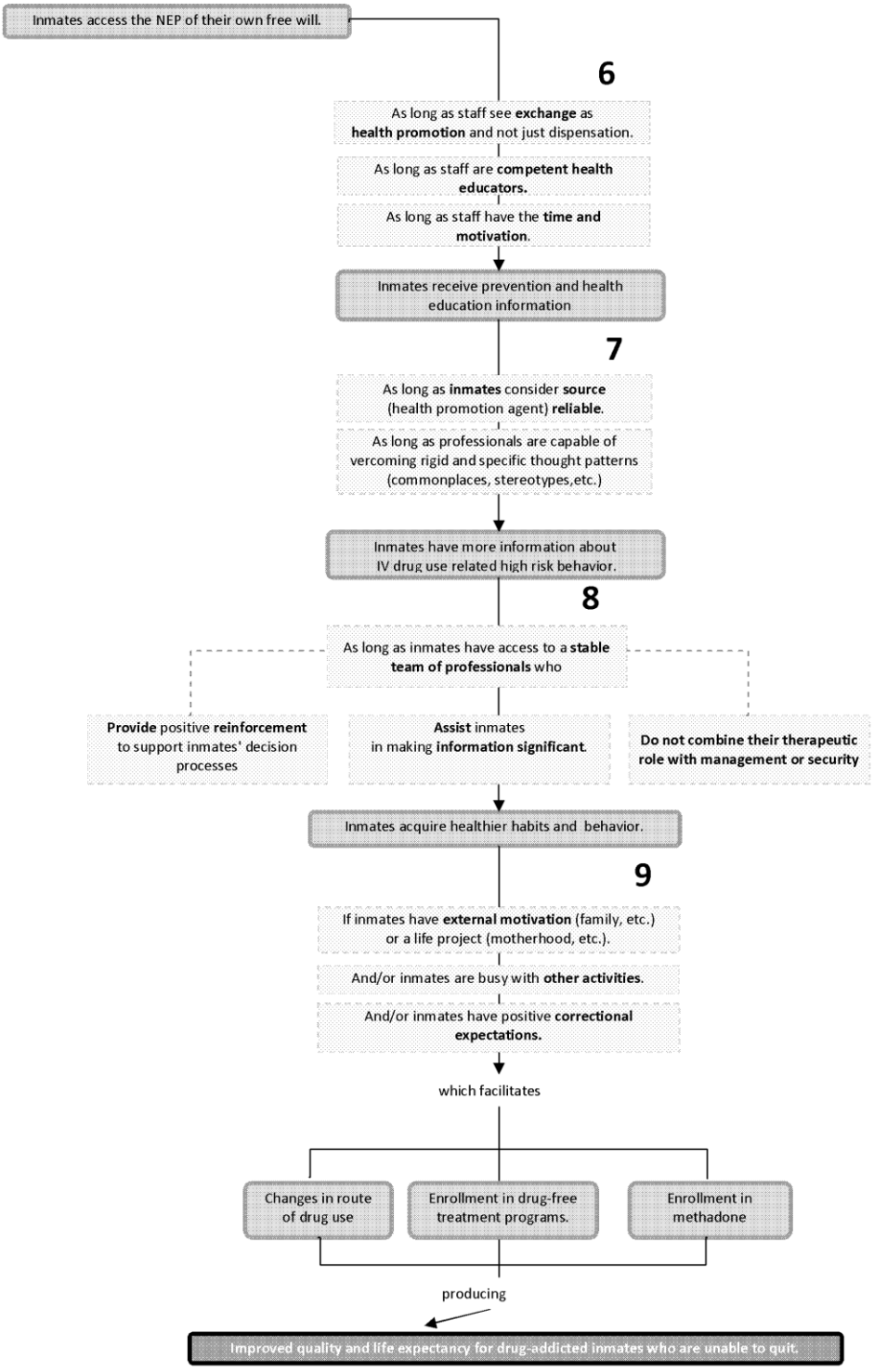
> "P5: **I think this bond is necessary**. Its may be a tool, but if it can be achieved... you never know. Lot's of people who shoot up on the street don't go to a center, they may go to a drugstore, the chemist at the drugstore doesn't have a bond with them, but nonetheless they are honest and responsible, aren't they?" (GI1)

> "There is a bond of trust with inmates which makes it **easier for them to join the NEP. But they nonetheless find it difficult.**" (GI4)

A therapeutic bond doesn't seem to be a requirement for harm reduction strategies. Nonetheless, given how NEPs are presently designed and implemented, keeping participants in a NEP does seem to involve creating a trusting relationship with inmates.

4.2.5. Sixth section of the NEP Change Theory

We will now present the results obtained from analyzing the series of assumptions and expected results from the sixth section of NEP Change Theory. (chart 5).



NEPs and Health Education

People who focus their narrative on **"transmission of infectious diseases"** do not see the core of NEPs as a health education initiative geared to modify behavior (change route; reduce use; abstinence). They see a NEP exclusively as a harm reduction program and state that other programs are already tasked with changing behavior.

They feel working towards "other goals" involves addressing health issues and problems that go beyond harm reduction. Limited education and experience could account for these health-problem-centred approaches.

> "R: ...there is an issue related to training. Some health professionals have a different background from a physician who specializes in addiction, whose specific experience gives him a greater awareness and leads him to understand that a drug user's process is different. He won't try to convince a user to just stop shooting up." (GI1)

However, when narratives are structured around the issue of "**drug use**" health education is seen as a core aspect of NEPs. It is taken for granted that the ultimate "goal" of a NEP is to raise inmates' awareness of the risks involved in drug uses and lead them to healthier habits (different route or abstinence).

> "P5: ...if someone is actively using now, the utlimate goal isn't abstinence. **The ultimate goal is to motivate that inmate to join a program**, for example. Or get him on methadone." (GI7)

> "After or before giving someone a needle kit you always have the option of getting that person and trying to **have an effect on what he is going to do**." (GI6)

to work toward this goal we need a system that connects a user with a professional in order to start a process of evaluation that may lead to behavior change.

> "(...) **you don't just give someone a needle and leave**. You give them a needle and you work towards the goal of not needing needles." (GI2)

These narratives see a NEP as another program in the overall management of inmate addiction.

> "Y**ou can't get anything done without a program behind you**. I think that is key." (GI2)

However, they acknowledge limited time prevents them from working with inmates in depth. The lack of coordination between different agents involved in each case and the inherent difficulties that each user has can threaten the program's success.

> "I'm on the NEP and also working with methadone. We do what we can. Nursing staff tries to provide essential health education and run the exchange. **But it's very complicated**. " (GI4)

5. Recommendations for improvement

The theoretical logic that underpins NEPs is unquestionable. Many precedents prove the benefit needle exchanges have on correctional institution inmates' quality of life. Available evidence has highlighted the fact that dispensing sterile needles reduces the use of dirty needles, and, consequently, IV-transmitted diseases. [24]

This fact is also supported by the information gathered in during this evaluation (from inmates and prison staff) and has led to the widespread perception that a well-implemented NEP "is a program that avoids high-risk behavior and contributes to risk reduction".

Nonetheless, between 2005 and 2010, global NEP participation data indicates that only 2.4% of inmates with a reported history of drug use actually participated in a program at some time (see annex 2, table 3).

Although it is true that not all inmates with a history of addiction actively use while in prison, it is also true (as we have seen in this evaluation) that:

a) IV drug use in prisons is definitely still a reality

b) not having a history of use or being on methadone doesn't necessarily preclude active use

Given those facts, and in order to understand the low rate of participation, the logic of NEP implementaton has been explored in depth (in order to identify those processes that have enabled or hindered program implementation).

This analysis has lead to results (see 4.2) and the shared analysis of these results (Comissió de Seguiment de l'Avaluació[25] / Evaluation Overview Comission) has produced two main lines of thought aimed at integrating correctional logic (treatment for social reintegration) and harm reduction.

This two lines of thought have addressed the basic issues underlying NEPs, such as the nature of its goals and access and needle management procedures.

Reviewing these issues has opened the door for major changes in the NEP framework, but has also shone a light on the fact that NEPs are implemented in complex environments where change cannot be effected without due time and process.

For this reason, in addition to the two main lines of thought, we have a third set of issues we have labeled "transitional".

These are recommendations that, in the light of the results of this evaluation, cannot explain on their own the low rate of NEP participation. However, in the context of a global and

[24] Many references provide internationally generated evidence supporting the effectiveness of prison needle exchange programs (see 4.1 of this final evaluation report). As for enhancing quality of life in Spanish correctional institutions, we would like to point out the report published in 2003 by the Sudireccion General de Sanidad (an office of the Spanish Ministry of Health) (Sanz et al. 2003) or NEP evaluations such as the one in Bilbao (Menoyo et al. 2000) of Pamplona (Villanueva, 2002).

[25] On October 21st 2010 the 3rd Evaluation Monitoring Committee workshop took place. The goal was identifying possible changes to NEPs, given the evaluation's early results.

incremental NEP change (addressing the recommendations from the first two sections) they may make progress easier.

All these issues have been examined and discussed by the Evaluation Monitoring Commission (see 3.2) and as a result of this shared work different levels have been identified within the NEP framework which require decisions geared towards change and improvement.

Decision 1: NEP goals

The results of this evaluation have led us to issue a recommendation that decisions be taken regarding NEP explicit goals.

We have already seen that harm reduction (and, more specifically, NEP) is understood in very diverse ways by correctional institution professionals.

On one side, there are professionals who see harm reduction (NEP) as the last rung of a therapeutic strategy ladder, whose overall goal is addressing what they see as the core problem : drug use.

In these cases, the relationship with the addicted inmates is defined by a therapeutic strategy that aims to achieve a drug-free person. In certain circumstances issuing a needle may be considered adequate, but this is always part of a larger therapeutic process that strives to achieve full rehabilitation.

On the other side, other professionals see harm reduction as a self-contained strategy. In fact, they may not see a NEP as a strategy, but rather as a right, to be implemented independently from other rehabilitation options.

In those cases, two separate endeavors are considered: on one hand action is taken to prevent contagion, while on the other action is taken to facilitate rehabilitation.

As we have seen in the outcome of this evaluation, when a NEP is seen as just another phase of a strategy geared towards a drug-free outcome, program access becomes more difficult (less information is available, to avoid encouraging drug use, access requirements are stricter, etc.) and participant adherence is also more difficult (less rule flexibility, etc.)

Decision making recommendations

The current written NEP document has not helped create a perception of this program as a harm reduction strategy, as a valid goal in itself.

Although the underlying intention that drives the work of the Departaments de Salut i Justícia (Departments of Health and Justice) of the Generalitat de Catalunya clearly heads in the direction of harm reduction, the current written version of the NEP program[26] may be partly responsible for the fact that professionals sometimes see needle dispensation as one more link (a last resort) in a therapeutic strategy aimed at rehabilitation.

[26] One of the explicit program goals is stated as “Promoting change in consumption routes” and “motivating users to achieve change in health behavior” is included as a task for professionals.

We recommend reviewing the text of the program in the light of these facts and explicitly describing NEP as a harm reduction strategy focused on addressing the problem of infectious disease transmission, implemented separately from whatever rehabilitation strategies that may be considered appropriate.

We recommend, based on the previously stated facts, that the written version of the program explicitly state if certain circumstances (such as methadone use, etc.) or precedents (no history of drug use, dangerous behavior, etc.) rule out (or don't, or to what extent) program access.

Decision 2: Access to needles

The outcomes of this evaluation process lead us to recommend that decisions be taken regarding how access to needles is regulated and the role of staff in this.

At the moment, health professionals act as an interface between participants and needles, managing needles and their access.

This contact with professionals is highly valued (by professionals and inmates) when a (formal, or informal) therapeutic bond arises. This is not the case, though, when inmates prefer to keep needle access separate from any other interaction with the institution.

In these cases, and regardless of how the professional team involved sees the NEP[27], the present system has encountered obstacles.

Where professionals have focused on maximizing NEP intake and maintenance, they have often had to engage in practical and rule-bending high-wire antics that shouldn't be required of them in normal conditions (and that don't always succeed in adjusting the NEP to addicts' needs : schedules, immediacy, etc.)

Where professionals stress the importance of using a NEP as a tool to help support inmates in their rehabilitation process, NEPs acquire rigid rules and procedures that makes the participation and adherence of inmates difficult (lack of trust, limited adjustment to the reality of addiction, etc.)

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[27] The role of professionals as needle access intermediaries has led to very different scenarios, including:

- Professionals may see a NEP as a goal in itself, or they may see it as part of a larger therapeutic rationale.

- Professionals may defend the idea that inmates are responsible for their drug use (and its consequences) or the belief in inmate lack of responsibility in health-related decision making may prevail.

- Professionals may not be afraid of the legal implications of needle dispensation or they may engage in defensive practices aimed at preventing such implications.

- Professionals may develop strategies to keep inmates and the fact they are participating in the program invisible as a priority or the priority may be control, rules and treatment, making inmates far more “visible” for the institution.

- Professionals may allow covert anonymous NEP access strategies or they may limit program participation to the established terms of confidentiality.

Decision making recommendations

Given the conditions in correctional institutions (where invisibility is held in high esteem by inmates) we recommend that the current needle distribution system (which is highly regarded by inmates with an interest in engaging with staff) be supplemented with a simplified access system that doesn't require intermediaries.

We recommend studying the possibility of transferring to Catalunya the solutions that have been implemented in other countries (Switzerland, Germany, Moldavia, Kyrgyzstan, Bielorussia) where the shortcomings of health professional participation have led to the adoption of anonymous needle access mechanisms (automatic dispensing or peer dispensation).

We would like to point out the results seen in other evalutations. The evaluation of the NEP in the German prisons of Vechta and Lingen (Stöver, 2000) reached the conclusion that where needle exchange has not been mediated by professional staff, the program has gained greater acceptance.

As we see in Catalunya, in German prisons where needles are supplied by health professionals there is a population of inmates who are unwilling to participate in a NEP because they do not want to be identified as drug users in the institution.

Similar outcomes are seen in the analysis of NEPs in countries such as Moldavia (Hoover and Jurgens, 2009), Kyrgyzstan (Lines et al., 2006) or Bielorussia (Savischeva, 2003).

Decision 3: Compelementary Measures

In the correctional treatment setting, drug use by a person who has been sentenced for a drug-related crime is considered a recidivism risk factor.

This sets a complex stage where proof of drug use may be a major factor in progress (or regression) on the correctional privilege ladder. That means that no harm reduction strategy can be perceived by inmates as a decision that will single them out as drug users, jeopardizing their access to leaves and other privileges.

That is why the previous two recommendations stress the need to keep needle dispensation separate from treatment and well hidden from the view of an institution that is embodied (for better and for worse) by health professionals with many different approaches to harm reduction.

However, the results of this evaluation lead us to recommend taking decisions relative to a a series of issues that may not, on their own, transform the underlying problems, but that may help us take steps in the right direction.

These issues are:

- Raising the awareness of politicians and correctional institution managers of the rights involved in harm reduction programs.
- Educating institution staff members about how harm reduction programs work.
- Considering sharing know-how between community-based needle exchange programs and institution staff.

- Finding ways of engaging inmates in shared responsibility for their health.
- Specific needle access procedures when a professional is involved (schedules, staff that is authorized to dispense, etc.)
- Exchange kit content.

Decision making recommendatons

3.1. Education and raising awareness of harm reduction programs

This evaluation has laid bare the wide range of interpretations (and experiences) related to harm reduction.

In fact, different involved professionals have voiced a concern that they lack the resources to integrate in their practice something they presently consider negligence: “allowing someone to use drugs without doing anything to stop him”.

The Evaluation Monitoring Commission has given rise to the view that adequately integrating harm reduction perspectives in correctional institutions requires action in two areas.

On the one hand, political work targeting officials ultimately responsible for the program in government and within these institutions.

On the other, widespread training for professionals (in health and other fields) in prisons, covering addiction management in general and also covering, more specifically, the nature of harm reduction.

Another initiative that should be kept in mind in the creation of alternative activities (such as workshops or conferences) designed to share experience and bring together community-based professionals and correctional institution staff. Shared learning and change should ensue.

3.2. Drug-addicted inmates and their responsibility

One of the circumstances that – as we have seen- changes scale according to who's point of view we take is the greater (or lesser) responsibility attributed to inmates in their decision making processes.

Sometimes this removal of responsibility emerges in subtle forms (not allowing methadone program participants to acces NEPs) while in other instances it is more obvious (defensive practices, resulting from staff fear of legal implications).

In these more blatant circumstances, the Monitoring Commission recommends weighing the advantages and disadvantages of including in the program participation contract a clause establishing shared responsibility of the consequences of needle use (overdose, etc.) with NEP users.

3.3. Needle access

This evaluation has made certain limitations of professionally-mediated needle access quite clear: trust issues with some inmates, difficulties adjusting to the reality of addiction (schedules, immediacy, etc.), some professionals who restrict NEP access, etc.

In spite of all this, and in the context of incremental overall NEP change, it is advisable that, as long as professionals are tasked with needle dispensation, distribution should strive to meet the specific traits of addiction: round the clock access to needles, as fast as possible.

The advantages and disadvantages of maximizing the range of institution professionals involved (permanently or temporarily) in the distribution process should be carefully evaluated.

The possibility of increasing the number of needles issued in each exchange should also be considered. Swiss experience at the Hindelbank prison, where a syringe is always dispensed with five additional needles, to be used before the next exchange[28].

3.4. Exchange kit content

During the evaluation process multiple participants have reported shortcomings in present exchange kit content. The absence of a spoon or other heatable container for dose preparation has been specifically mentioned. This has been cause of concern because it has led to sharing with other users or to resorting to unsanitary equipment.

The advantages and disadvantages of expanding kit content should be evaluated.

[28] In order to avoid repeated use of needles issued by the NEP the Swiss Hindelbank prison dispenses 5 clean needles with each syringe. This practice has not resulted in security problems in this institution. (Lines et al. 2006)

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Annexes

Annex 1

NEP evaluation matrices.

Catalonian correctional institution Needle Exchange Program (NEP) evaluation matrix.

Category: Working document Date: February 16 2010 Version: First

Introduction and purpose:

1.- Description of the evaluation questions addressed in field work.
2.- List of indicators that may lead to answers and information sources required.

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
Intermediate results	Has the needle exchange program been implemented in every correctional institution (CI) in Catalonia?	Number of correctional institutions (CI) in Catalunya where NEP has been implemented.	.....	Justice Department records
	Has it been possible to adapt the Reference Program to the specific conditions in each center?	Involved professionals' subjective perception[29] regarding the circumstances in which the NEP has been adapted to each CI.	Participation mechanisms involving different stakeholders in design and implementation (information channels connecting each area) Program negotiation and readjustament Agreements reached to apply the NEP in each center.	Group interviews. Professionals participate in online poll.
	Do members of different professions agree in acknowledging IV drug use as a health proglem in jails? On what terms?	Involved professionals' subjective perception regarding the circumstances in which the NEP has been adapted to each CI.	Information provided about the health problem. Perceptions of IV drug use (health problem, control problem, a personal problem involving social context; etc.) How the concepts "NEP" and "Prevention" are related.	Group interviews. Professionals participate in online poll.
	Do members of different professions agree that a NEP can help solve the stated health problem? What role have the different groups had in NEP design and implementation?	Involved professionals' subjective perception regarding the circumstances in which the NEP has been adapted to each CI.	Participation mechanisms involving different stakeholders in design and implementation (information channels connecting each area) Values and beliefs affecting the program and IV drug use management	Group interviews. Professionals participate in online poll.

[29] Unless otherwise stated, when discussing involved professionals, we are including: treatment staff, institution healthcare professionals, prison officers and specific addiction treatment program staff (where available).

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
PROCESSES			Role of different groups in the decision making process .	
	What changes have been seen in drug use, assaults and overdose incidents since NEP deployment?	Changes in number of inmate assaults on staff since NEP deployment. Changes in number of assaults involving a NEP needle. Changes in number of assaults involving a NEP participant. Changes in number of overdoses since NEP deployment. Changes in IV drug use. Number of overdoses involving a NEP participant.	.....	Records of each CI department.
	What implications has the diversity of "visions" of IV drug use management had on successful NEP deployment in institutions? Which factors have expedited or hindered the management of these differences and integration into a shared vision?	Narratives and practices presented by different professionals related to their understanding of IV drug use management in institutions	Seeing this reality from the point of view of control. Seeing this reality from the point of view of health problems. Seeing this reality from the point of view of institutional rehabilitation. Current discussion mechanisms. Values and beliefs about the program and IV drug use management. Program negotiation and readjustment	Group interviews. Professionals participate in online poll.
Interediate results	Has the program been accepted by all the professional groups involved and is it currently fully active in every Catalonian prison?	Involved professionals' subjective perception regarding program acceptance in different institutions. Involved professionals' subjective perception regarding the degree of full current deployment.	.....	
	How does degree of involvement of institution senior management affect successful NEP implementation?	Involved professionals' subjective perception of institution management's influence on NEP.	Greater involvement leads to enhanced NEP presence in a prison.	
	Are all professionals and staff members aware of the fact the NEP exists? Do they have timely information? Do they take on the role of "information agent" about the NEP in their contact with inmates? Has information received by treatment and security professionals changed their understanding of the NEP? Are inmates aware of the existence of a NEP? Do they have clear and sufficient	Involved professionals' subjective perception of their own awareness NEP and if presently Involved professionals' subjective perception of their role as NEP "information agents".	Existència de material informatiu: pòsters, llibrets, etc... Usabilitat del material Iniciatives de formació i difusió del PIX La sensibilització envers el PIX Paper dels col·lectius de vigilància i tractament a l'hora d'informar del PIX	Group interviews. Professionals participate in online poll. Group interviews. Inmate individual interviews. Inmate poll.

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
PROCESSES	information?			
	Do inmates have information about NEP terms of confidentiality and information management? Does fear of forfeiting privileges keep inmates out of the NEP? If so, what are the specific reasons? Does fear of being extorted by other inmates keep inmates out of the NEP? If so, what are the specific reasons?	Involved professionals' subjective perception of their own awareness NEP and if regarding issues that can impact NEP participation: confidentiality, privileges, extortion, etc.	Confidentiality of information Information management (who knows what?) Penitentiary rules and their impact on NEP. Illegal inmate behavior.	Group interviews. Individual inmate interviews. Inmate poll.
	What "pros and cons" do inmates have in mind when evaluating the option of accessing institution-provided needles?	All involved parties' subjective perception of "institution needles".	Pros and cons of legally accessing the program. Key issue: why do some inmates prefer a needle obtained by other means?	Group interviews. Individual inmate interviews. Inmate poll.
	Does staff have clear criteria and solid legal guarantees regarding who can access the program?	Is there a clear consensus about program access criteria?	NEP participation of inmates on METHADONE. NEP participation of inmates with no history of drug use.	Group interviews. Professionals participate in online poll.
Intermediate results	Are drug-addicted inmates in Catalonian prisons enrolling in the NEP?	Number of NEP participants, compared to estimate of total drug using inmate population.	Indirect indicators: number of inmates in methadone programs + number of drug-related confiscations + number of inmates with a history of injection + data from Spanish National Drug Plan 2007	Group interviews Records from each CI.
	How high a priority do inmates assign to their health? How does this affect their participation (or lack of it) in the NEP?	All involved parties' subjective perception of the implications of NEP participation and the priority personal health has for inmates.	Reasons to enroll in the program. Risk perception of the involved risk behavior (sharing needles).	Group interviews. Individual inmate interviews.

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
PROCESSES	Is needle exchange quick and easily accessible in all prisons?	All involved parties' subjective perception of the conditions in which needle exchange takes place in prisons.	Program intake procedures. Ease with which the exchange can take place confidentially. Are assigned spaces appropriate?	Group interviews. Individual inmate interviews.
Intermediate results	Do inmates who participate in the NEP consistently exchange used needles?	Percentage of issued needles that are returned as the program requires.	.....	Records of different CI departaments.
	Es donen casos en els que els interns boicotegin el PIX? Com? Per quins motius?	All involved parties' subjective perception of how inmates relate to the NEP.	Not sharing a cell with a NEP participant.	
	Does covert unwarranted use of needles occur? Does this affect program recruitment? Do this compromise successful day to day Program operation?	All involved parties' subjective perception of the potential for needle abuse and how that affects program operation.	Needle rental. "Solidarity" with other inmates. Needle sales. Professional strategies for dealing with unwarranted inmate needle use: therapeutic contracts	Group interviews. Individual inmate interviews.

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
PROCESSES	Does the NEP provide the equipment required for IV drug use?	Degree of match between supplied by the NEP and what is considered necessary.	Filters required for IV drug use. "Cookers" required for IV drug use.	Group interviews.
Intermediate results	Has the tendency to share needles and use unsanitary equipment diminished among inmates who participate in the NEP?	All involved parties' subjective perception of NEP effect in changing high-risk equipment-sharing behavior. Trends in number of non-Program needles (and other injection equipment) confiscated while NEP active.	Intentions related to IV drug use.	Group interviews. Records of each relevant CI department. Individual inmate interviews.

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
Intermediate results	Has the rate of transmission of IV-drug-use-related infectious diseases among inmates seen a reduction since the date of NEP deployment?	Changes in data reflecting IV drug use related infectious disease transmission among inmates	.....	Records of each CI department.
[redacted]				
	Is needle exchange perceived and implemented by professional staff as “health promotion” or just as a dispensation? Why?	Narratives and practices maintained by different groups of professional staff around needle dispensation.	Meaning attached to needle exchange. Dispensation model vs. Health promotion model	Group interviews
	Is the professional staff in charge of needle exchange a competent provider of health education?	Narratives and practices maintained by different groups of professional staff regarding health education practices.	Skill and knowledge coaching. Insight facilitation. Communication and interpersonal skills Subject expertise.	Group interviews

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
PROCESSES	Does staff in charge of needle exchange have the time and motivation to turn needle dispensation into a health promotion opportunity?	Narratives and practices maintained by different groups of professional staff regarding needle dispensation.	Enabling and limiting factors towards the goal of turning needle exchange into a health promotion opportunity.	Group interviews
Intermediate results	Have inmates participating in the NEP had access to health education?	Number and type of health education initiatives developed in prisons aimed at addressing high-risk IV drug-use-related behavior.	.....	Records of each CI department.
	In what circumstances do inmates consider a source of information (a health promotion agent) reliable?	All involved parties' subjective perception regarding which circumstances enhance a health promotion agent's reliability as a source of information.	Cooperation and connivance between inmates and health promotion agents. The importance of health promotion agents.	Group interviews. Individual inmate interviews.

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
PROCESSES	Does NEP staff take into account inmates' values and beliefs regarding drug use? What factors help (or hinder) this goal?	Narratives and practices maintained by different groups of professional staff involved in needle exchange.	Commonplaces and stereotypes maintained by inmates about IV drug use. Strategies to move beyond rigid and limited narratives.	Group interviews. Individual inmate interviews.
Intermediate results	Are inmates more knowledgeable about IV drug use related high risk behaviour?	Inmates' subjective perception of their own knowledge of IV drug use related high risk behavior.	Knowledge of IV drug use related high risk behavior and their context. Knowledge of effective preventive practices. Skills such as deploying behavior incompatible with high risk behavior. Awareness of short and long term consequences of high risk behavior.	Individual inmate interviews. Inmate poll.

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
Intermediate results	Have inmates participating in the NEP acquired healthier habits and behaviors?	Changes in drug administration route used by inmates enrolled in the NEP. Number of NEP participants who subsequently enroll in a drug-free program. Number of NEP participants who subsequently enroll in a methadone program.	.....	Records of each CI department. Inmate poll.

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information

	Evaluation questions	Indicators/Dimensions	Topics to be explored	Sources of information
FINAL RESULT				

Annex 2

Main health indicators among Catalonian prison inmates and the NEP program

QUANTITATIVE EVALUATION INDICATORS FOR THE NEEDLE EXCHANGE PROGRAM IN CATALONIAN CIs

	Year 2003	Year 2004	Year 2005	Year 2006	Year 2007	Year 2008
Table 1. Prison population change. Past data.						
	6.931	7.517	8.176	8.359	9.010	9.413

Total number of inmates (remanded, convicted and court-ordered detainees)at midnight on the last day of each year. Doesn't include weeked detention.

Source: Justice Department, Generalitat de Catalunya

	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Table 2. Inmates who report a history of IV drug use.					
	2.992	2.822	2.811	2.617	2.448
Percentage of total prison population	36,6%	33,8%	31,2%	27,8%	24,3%

Source: Justice Department, Generalitat de Catalunya

	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009	Average
Table 3. Inmates paricipating in the NEP	91	53	54	89	48	
Number of NEP participants, as percentage of total population reporting a history of IV drug use	3,0%	1,9%	1,9%	3,4%	2,0%	**2,4%**
Persones internes usuaàries del PIX, sobre el total de les que manifesten antecedents de consum, i no están en programes de Metadona	13,2%	9,0%	10,7%	31,6%	37,5%	

	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Taula 4. Number of needles dispensed through the NEP program	321				

	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Taula 5. NEP participant inmates as percentage of population reporting history of IV drug use and not participating in methadone programs.					
	13,23	9,01	10,65	31,56	37,50

	Year 2003	Year 2004	Year 2005	Year 2006	Year 2007
Table 6. Year of NEP deployment in each CI.					
Centre Penitenciari Brians 1				X	
Centre Penitenciari Brians 2					
Centre Penitenciari d'Homes de Barcelona					
Centre Penitenciari de Dones de Barcelona			X		
Centre Penitenciari de Figueres			X		
Centre Penitenciari de Girona			X		
Centre Penitenciari de Joves			X		
Centre Penitenciari de Tarragona	X				
Centre Penitenciari Ponent		X			
Centre Penitenciari Quatre Camins				X	

	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Table 7. Annual number of incidents involving assault on staff by an inmate.					
Number of assaults on staff registered in all CIs each year.	48	32	46	76	73
CI inmate population	13463	13767	15438	16308	17209
Incidents per 100 inmates	0,36	0,23	0,30	0,47	0,42

Table 8. Incidents requiring urgent medical care as a result of an overdose in each CI.	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Centre Penitenciari Brians 1	29	27	29	33	32
Centre Penitenciari Brians 2			2	21	31
Centre Penitenciari d'Homes de Barcelona	16	14	6	5	11
Centre Penitenciari de Dones de Barcelona	8	2	1	1	2
Centre Penitenciari de Figueres	0	0	0	0	0
Centre Penitenciari de Girona	0	0	0	0	0
Centre Penitenciari de Joves	1	1	0	2	2
Centre Penitenciari de Tarragona	3	2	0	1	1
Centre Penitenciari Ponent	0	8	3	3	4
Centre Penitenciari Quatre Camins	36	30	35	26	22
	93	84	76	92	105

Table 9. Number of inmates with a reported history of IV drug use in each CI. Some individuals are counted more than once as a result of inmate mobility.	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Centre Penitenciari Brians 1	671	599	572	414	390
Centre Penitenciari Brians 2			231	510	545
Centre Penitenciari d'Homes de Barcelona	734	686	651	509	424
Centre Penitenciari de Dones de Barcelona	74	64	49	47	42
Centre Penitenciari de Figueres	46	44	33	28	25
Centre Penitenciari de Girona	92	88	70	70	68
Centre Penitenciari de Joves	80	58	51	37	11
Centre Penitenciari de Tarragona	145	143	134	122	126
Centre Penitenciari Ponent	368	326	283	250	247
Centre Penitenciari Quatre Camins	782	814	737	630	570
	2992	2822	2811	2617	2448
		-170	-11	-194	-169

	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Table 10. Number of inmates participating in methadone maintenance programs. Some individuals are counted more than once as a result of inmate mobility.					
Centre Penitenciari Brians 1	502	447	414	321	337
Centre Penitenciari Brians 2			130	365	404
Centre Penitenciari d'Homes de Barcelona	754	703	765	695	668
Centre Penitenciari de Dones de Barcelona	85	63	78	72	65
Centre Penitenciari de Figueres	40	40	37	41	39
Centre Penitenciari de Girona	55	62	48	48	48
Centre Penitenciari de Joves	11	9	12	16	5
Centre Penitenciari de Tarragona	121	117	87	105	113
Centre Penitenciari Ponent	299	304	264	249	243
Centre Penitenciari Quatre Camins	437	489	469	423	398
	2304	2234	2304	2335	2320

	Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Table 11. Inmates with a history of IV drug use who are not enrolled in a methadone program					
	688	588	507	282	128

Table 12. Centre Penitenciari Brians 1				
Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Number of inmates with a history of IV drug use reported by CI each year.				
671	599	572	414	390
Number of CI inmates enrolled in a methadone maintenance program				
502	447	414	321	337
Percentage of inmates with a history of VI drug use who are NOT enrolled in a methadone program				
25,2%	25,4%	27,6%	22,5%	13,6%
Percentage of inmates with a history of VI drug use who are enrolled in the NEP				
…	…	2,4%	9,2%	5,4%
Number of NEP participants reported each year by this CI				
…	…	14	38	21
Number of needles dispensed by the NEP in this CI each year				
…	…	56	292	513
Number of needles per NEP participant				
		4	8	24

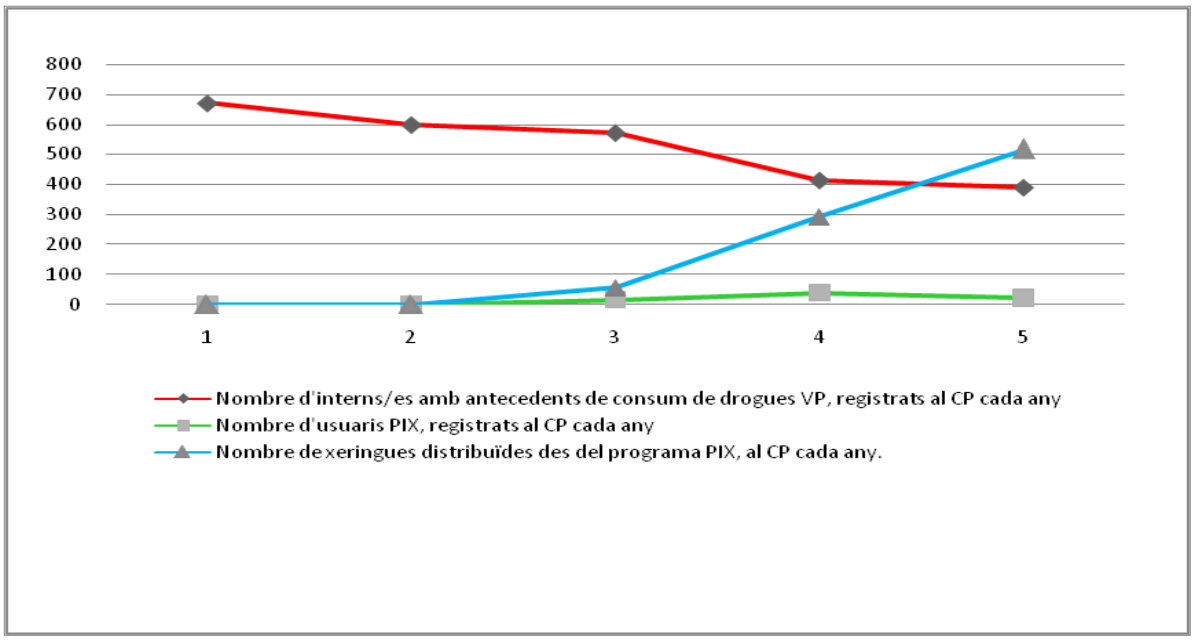
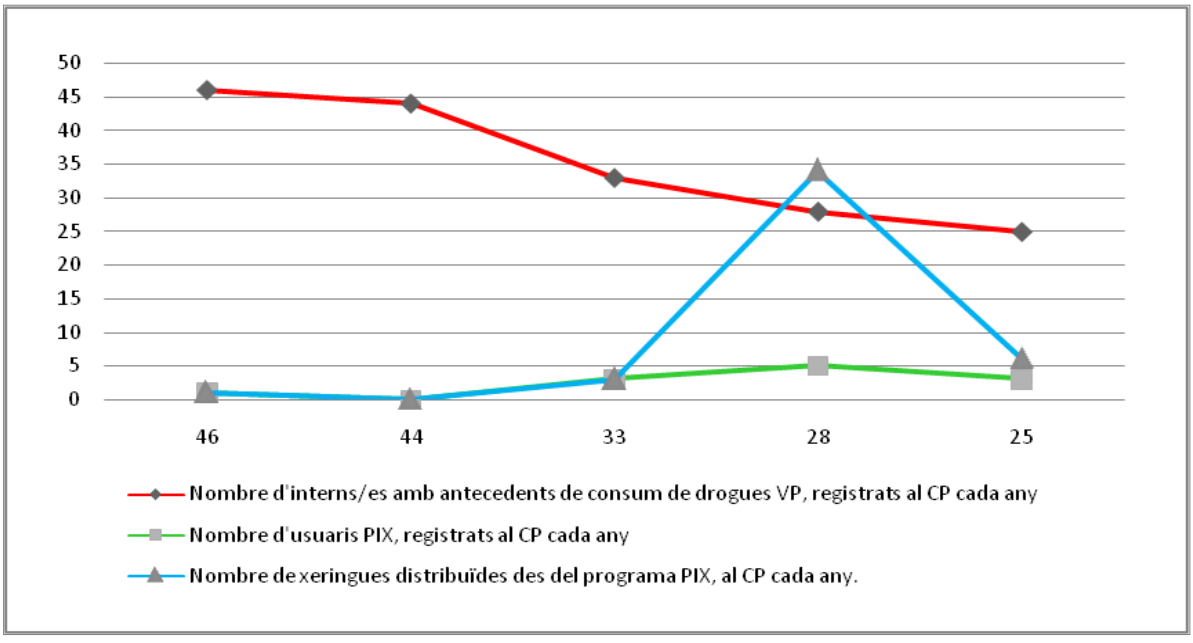
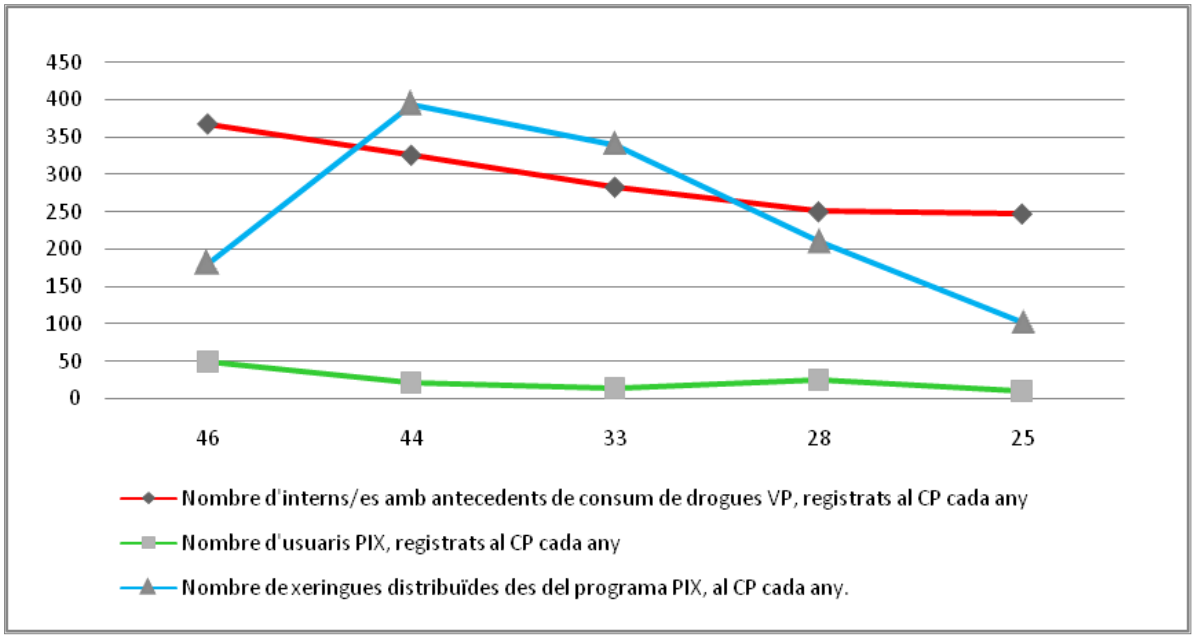


Table 13. Centre Penitenciari de Figueres				
Year 2005	Year 2006	Year 2007	Year 2008	Year 2009
Number of inmates with a history of IV drug use reported by CI each year.				
46	44	33	28	25
Number of CI inmates enrolled in a methadone maintenance program				
40	40	37	41	39
Percentage of inmates with a history of VI drug use who are NOT enrolled in a methadone program				
13,0%	9,1%	-12,1%	-46,4%	-56,0%
Percentage of inmates with a history of VI drug use who are enrolled in the NEP				
2,2%	0,0%	9,1%	17,9%	12,0%
Number of NEP participants reported each year by this CI				
1	0	3	5	3
Number of needles dispensed by the NEP in this CI each year				
1	0	3	34	6
Number of needles per NEP participant				
		1	7	2



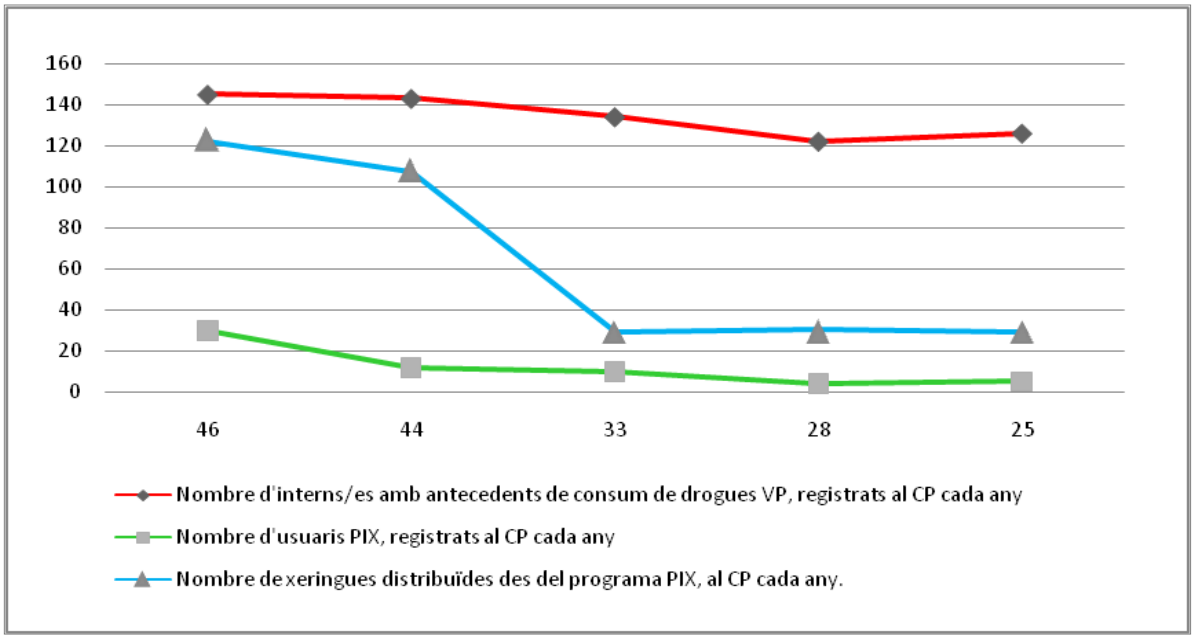
Taula 14. Centre Penitenciari Ponent				
Any 2005	Any 2006	Any 2007	Any 2008	Any 2009
Number of inmates with a history of IV drug use reported by CI each year.				
368	326	283	250	247
Number of CI inmates enrolled in a methadone maintenance program				
299	304	264	249	243
Percentage of inmates with a history of VI drug use who are NOT enrolled in a methadone program				
18,8%	6,7%	6,7%	0,4%	1,6%
Percentage of inmates with a history of VI drug use who are enrolled in the NEP				
13,6%	6,7%	4,9%	10,0%	4,0%
Number of NEP participants reported each year by this CI				
50	22	14	25	10
Number of needles dispensed by the NEP in this CI each year				
181	393	339	210	102
Number of needles per NEP participant				
		24	8	10



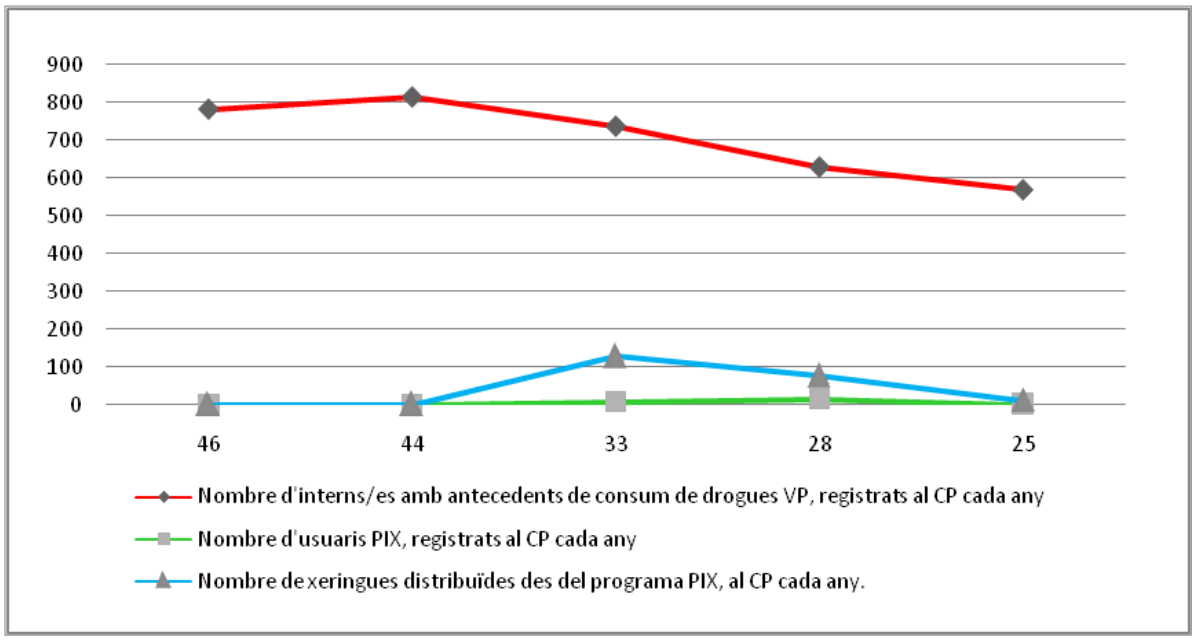
Taula 15. Centre Penitenciari Brians 2				
Any 2005	Any 2006	Any 2007	Any 2008	Any 2009
Number of inmates with a history of IV drug use reported by CI each year.				
0	0	231	510	545
Number of CI inmates enrolled in a methadone maintenance program				
0	0	130	365	404
Percentage of inmates with a history of VI drug use who are NOT enrolled in a methadone program				
...	...	43,7%	28,4%	25,9%
Percentage of inmates with a history of VI drug use who are enrolled in the NEP				
		0,0%	0,0%	1,1%
Number of NEP participants reported each year by this CI				
...	...	0	0	6
Number of needles dispensed by the NEP in this CI each year				
0	0	0	0	39
Number of needles per NEP participant				
				7

Taula 16. Centre Penitenciari de Girona				
Any 2005	Any 2006	Any 2007	Any 2008	Any 2009
Number of inmates with a history of IV drug use reported by CI each year.				
92	88	70	70	68
Number of CI inmates enrolled in a methadone maintenance program				
55	62	48	48	48
Percentage of inmates with a history of VI drug use who are NOT enrolled in a methadone program				
40,2%	29,5%	31,4%	31,4%	29,4%
Percentage of inmates with a history of VI drug use who are enrolled in the NEP				
		0,0%	0,0%	1,5%
Number of needles dispensed by the NEP in this CI each year				
0	0	0	0	1
Number of needles per NEP participant				
0	0	0	0	0

Taula 17. Centre Penitenciari de Tarragona				
Any 2005	Any 2006	Any 2007	Any 2008	Any 2009
Number of inmates with a history of IV drug use reported by CI each year.				
145	143	134	122	126
Number of CI inmates enrolled in a methadone maintenance program				
121	117	87	105	113
Percentage of inmates with a history of VI drug use who are NOT enrolled in a methadone program				
16,6%	18,2%	35,1%	13,9%	10,3%
Percentage of inmates with a history of VI drug use who are enrolled in the NEP				
20,7%	8,4%	7,5%	3,3%	4,0%
Number of NEP participants reported each year by this CI				
30	12	10	4	5
Number of needles dispensed by the NEP in this CI each year				
122	107	29	30	29
Number of needles per NEP participant				
		3	8	6



Taula 18. Centre Penitenciari Quatre Camins				
Any 2005	Any 2006	Any 2007	Any 2008	Any 2009
Number of inmates with a history of IV drug use reported by CI each year.				
782	814	737	630	570
Number of CI inmates enrolled in a methadone maintenance program				
437	489	469	423	398
Percentage of inmates with a history of VI drug use who are NOT enrolled in a methadone program				
44,1%	39,9%	36,4%	32,9%	30,2%
Percentage of inmates with a history of VI drug use who are enrolled in the NEP				
0,0%	0,0%	0,9%	2,2%	0,2%
Number of NEP participants reported each year by this CI				
0	0	7	14	1
Number of needles dispensed by the NEP in this CI each year				
0	0	127	75	10
Number of needles per NEP participant				
		18	5	10



Annex 3

Interview Participant Listing

List of professionals participating in exploratory interviews

Participant	Background	Date
P1	Addiction clinic coordinator	25 January 2010
P2	Physician	26 January 2010
P3	Physician	26 January 2010
P4	Addiction clinic coordinator	29 January 2010
P5	Health care coordinator	3 February 2010
P6	CI nursing supervisor	3 February 2010
P7	Head of unit	3 February 2010

List of professionals participating in group interviews

Date: 16 March 2010	
Participant	**Background**
P1	Addiction Clinic Psychologist
P2	Nurse Addiction Clinic
P3	Nurse Addiction Clinic
P4	Nurse Addiction Clinic
P5	Social educator
P6	Social educator
P7	Social worker

Date: 16 March 2010	
Participant	**Background**
P1	Physician Addiction Clinic
P2	Social educator
P3	Social educator
P4	Psychologist
P5	Nurse
P6	Nurse

Date: 29 April 2010	
Participant	**Background**
P1	Addiction treatment unit prison officer
P2	Prison officer
P3	Prison officer
P4	Unit leader
P5	Prison officer
P6	Prison officer

Date: 4 May 2010	
Participant	**Background**
P1	Physician
P2	Nurse
P3	Nurse
P4	Physician
P5	Nurse
P6	Physician

Date: 6 May 2010	
Participant	**Background**
P1	Nurse
P2	Nurse
P3	Physician
P4	Physician
P5	Nurse
P6	Nurse

Date: 12 May 2010	
Participant	**Background**
P1	Physician
P2	Physician
P3	Physician
P4	Social educator

Date: 16 March 2010	
Participant	**Background**
P1	Coordinator and psychologist
P2	Psychologist
P3	Psychologist
P4	Psychologist
P5	Social educator
P6	Social educator
P7	Psychologist

Date: 25 May 2010	
Participant	**Background**
P1	Physician
P2	Nurse
P3	Physician
P4	Nurse

List of interviewed inmates

Participant	Background	Date
P1	Man, CI Brians 2	14 April 2010
P2	Man, CI Brians 2	14 April 2010
P3	Man, CI Brians 2	14 April 2010
P4	Man, CI Brians 2	14 April 2010
P5	Man, CI Q. Camins	28 April 2010
P6	Woman, CI Brians 1	29 April 2010
P7	Man, CI Q. Camins	28 April 2010
P8	Man, CI Q. Camins	28 April 2010
P9	Woman, CI Brians 1	29 April 2010

List of interviewed former inmates

Participant	Background	Date
P1	Male patient, Addiction Clinic, Ciutat Vella (Barcelona)	27 May 2010
P2	Male patient, Addiction Clinic, Ciutat Vella (Barcelona)	27 May 2010
P3	Male patient, Addiction Clinic, Ciutat Vella (Barcelona)	27 May 2010
P4	Male patient, Addiction Clinic, Ciutat Vella (Barcelona)	27 May 2010
P5	Male patient, Addiction Clinic, Ciutat Vella (Barcelona)	10 June 2010

List of correctional institutions where interviewed professionals work

Correctional institutions
Centre Penitenciari Brians 1
Centre Penitenciari Brians 2
Centre Penitenciari Ponent
Centre Penitenciari Dones
Centre Penitenciari Tarragona
Centre Penitenciari Quatre Camins
Centre Penitenciari Joves
Centre Penitenciari Lledoners
Centre Penitenciari Figueres
Centre Penitenciari Girona

Annex 4

Interview question lists

PROFESSIONAL AND STAFF INTERVIEWS

1. Importance of NEP presence in CIs

Do different types of professionals agree in acknowledging IV drug use in prisons as a problem? In what terms? Health? Safety? Biosocial?

2. What factors do you think facilitated or hindered adequate NEP deployment in your CI?

Has it been possible to adapt the terms of the Reference Program to the specific conditions of each center?

Have the different professional groups involved accepted this program and is it fully functional in every correctional institution in Catalonia? What implications has the existence of very diverse understandings of IV drug use management had on successful NEP deployment?

Has information about NEPs supplied to prison officers and treatment staff changed the way they see this program?

What influence does each center's management degree of commitment with the NEP have on the program's successful implementation?

3. Which "factors" or "processes" should we identify as "key" for good program operation?

<u>As may affect your own work:</u>

Is needle exchange timely and easily accessible in all centers? Program recruitment procedures: ability to communicate confidentially; provision of adequate space. Does staff have clear criteria and a solid legal framework regarding program access?

How can inmates best learn about the NEP? Are all staff groups aware of the NEP? Do they have current information? Do they actively disseminate information about the NEP among inmates? Are inmates aware of the existence of a NEP? Do they have clear and sufficient information? Are they familiar with the confidentiality and information management procedures used in the NEP?

<u>May not be related to your own work:</u>

Do inmates avoid NEP participation out of fear of jeopardizing leave and other privileges? If so, why?

Do inmates avoid NEP participation out of fear of being extorted by other inmates? If so, why?

External motivation (family, etc.) or a life project (motherhood,etc) as factors.

Being engaged in other activities as a factor.

Expectation of progress within the correctional process as a factor.

4. What underlying reality does a NEP address[30]? Could it be otherwise dealt with?

[30] We are referring to what participants see as the ultimate program goal. May include drug use, inmate quality of life, contagious disease transmission through needle sharing, etc...

Do different professional groups agree that a NEP may be an solution for the mentioned health problems? What role do different professions play in NEP design and implementation?

5. What reasons may lead a IV-drug-using inmate to avoid participating in a NEP?

What “pros and cons” do inmates see in access to institution-provided needles?

From inmates' point of view, how high a priority is health? How does this affect their participation (or lack of it) in a NEP?

Do you feel there are mechanisms which detract from NEP effective implementation?

Program boycott by inmates, or by other staff members.

Illicit needle use.

Weight carried by non-institutional drug use: resistance, drug use as meaningful ritual, etc.

6. What makes the NEP a useful program?

Has the tendency to share needles and use unsanitary equipment diminished among program participants?

Does exchange go beyond needle dispensation (i.e. a health promotion opportunity)

Professionals and their competence as health promotion agents: keeping in mind inmates' beliefs and values, etc. Professionals with enough time and motivation. Professionals as valid source in the eyes of inmates:stable and trustworthy reference, etc.

Existence of other high-risk activities related to contagious disease transmission.

INMATE INTERVIEWS

1. Awareness and information about the NEP

Awareness of published materials: posters, brochures, etc. Usability of existing materials.

Who do they get information from. Quality of that information. Initiatives to spread information and raise awareness of the NEP.

Role of security and treatment staff in providing information about the NEP.

2. Confidentiality and information management in the NEP?

Information managment (who knows what?).

Specfic factors related to correctional process. How inmate privileges are related to confidentiality. Explore if fear of losing access to leave and other privileges affects inmate NEP enrollment.

Confidentiality among inmates. Explore what factors lead to breaches.

Clandestine inmate activity.

3. Advantages of accessing needles through the institution?

Pros and cons of institution program access.

Key issue: why do some inmates choose to use illicitly obtained needles?

Value of health as factor in enrolling in the program. Risk perception of high-risk activity (needle sharing).

4. Ease of exchange access

Explore program enrollment procedures.

Ease, confidentiality and timeliness of exchange access

Are used spaces appropriate?

5. Needle use

Is covert illicit needle use rampant? Does this affect program enrollment? Does this affect program operation? Needle rental. “Solidarity” among inmates. Needle sale.

Staff strategies for working with inmates who illicitly use needles: therapeutic arrangements.

6. Drug use and health education.

Intentions related to IV drug use. Has the tendency of inmates who participate in the NEP to share needles and use unsanitary equipment diminished?

Explore other high-risk activities (tattoos, unprotected sex, etc.)

Are there other programs that address those issues? Other programs dealing with infectious disease transmission.

Staff-inmate rapport. In what circumstances to inmates consider health agents a reliable source?

Knowledge and awareness of high-risk situations and behaviors related to IV drug use. Knowledge of effective preventive practices. Skill in practicing alternative (risk-incompatible) behaviour. Awareness of short- and long-term consequences of high-risk behaviors.