

Schriftenreihe „Gesundheitsförderung im Justizvollzug“ – „Health Promotion in Prisons“

Herausgegeben von H. Stöver, J. Jacob

„Gesundheitsförderung zielt auf einen Prozess, allen Menschen ein höheres Maß an Selbstbestimmung über ihre Gesundheit zu ermöglichen und sie damit zur Stärkung ihrer Gesundheit zu befähigen. Um ein angemessenes körperliches und seelisches Wohlbefinden zu erlangen, ihre Wünsche und Hoffnungen wahrnehmen und verwirklichen, sowie ihre Umwelt meistern bzw. sie verändern zu können“. Diese Gedanken leiten die Ottawa-Charta zur Gesundheitsförderung ein, die 1986 von einer internationalen Konferenz verabschiedet wurde. Versucht man den Leitgedanken der Ottawa-Charta, die Stärkung der Selbstbestimmung über die Gesundheit, auf den Strafvollzug zu beziehen, stößt man schnell an Grenzen der Übertragbarkeit: Äußere Beschränkungen, Fremdbestimmungen, eingeschränkte Rechte prägen das Leben und die gesundheitliche Lage der Gefangenen.

Mit der Schriftenreihe „Gesundheitsförderung im Justizvollzug“ wollen wir Beiträge veröffentlichen, die innovative gesundheitspolitische Anregungen für den Justizvollzug geben und gesundheitsfördernde Praxisformen des Vollzugsalltags vorstellen.

Außerhalb des Vollzugs bewährte Präventionsangebote und Versorgungsstrukturen werden auf ihre Relevanz zur Verbesserung der gesundheitlichen Situation Inhaftierter hin überprüft und auf die Bedingungen des Justizvollzugs bezogen.

Letztendlich kann nur eine größere Transparenz und Durchlässigkeit des Systems „Justizvollzug“ dazu beitragen, individuelle gesundheitsorientierte Potentiale Gefangener anzuregen und zu fördern.

Die HerausgeberInnen

Heino Stöver / Katja Thane

Towards a Continuum of Care in the EU Criminal Justice System

A survey of prisoners' needs in four countries
(Estonia, Hungary, Lithuania, Poland)

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List of Abbreviations

AA	Alcoholics Anonymous
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral treatment
BBV	Blood-Borne Virus
CoE	Council of Europe
CPT	European Committee for the Prevention of Torture
DFU	Drug free unit
DOT	Directly observed therapy
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user
IEC	Information Education Communication
MoJ	Ministry of Justice
MoSA	Ministry of Social Affairs
NGO	Non Governmental Organisation
NPA	National Prison Administration
OST	Opioid Substitution Treatment
PDU	Problematic drug user
PLWHA	People living with HIV/AIDS
SD	Standard deviance
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary counselling and testing
WHO	World Health Organization

Executive Summary

Aims and objectives

Most of the New Member States of the EU have, to varying degrees, implemented effective treatment programmes and harm reduction projects outside of the prison system. However, effective drug treatment and Blood-Borne Virus (BBV) prevention programmes within the prison walls and follow up services for released inmates with problematic drug use still have to be developed in most New Member States. Overall, prison policies and practices, in particular in dealing with drug users and related (infectious) diseases, remain an important EU concern. In few of the New Member States does the public health imperative of a healthy prison system receive the political attention it deserves.

The objectives of the study are operationalised into concrete questions on (i) prevalence, (ii) nature and severity, (iii) characteristics and correlates of problematic drug use, including risk behaviours for HIV and other infectious diseases, (iv) need for care and treatment services and available support systems. The study also assesses differences in prevalence, nature, characteristics and need for services associated with gender and ethnicity.

Methods

The focus of this study was to collect data on and thereby increase knowledge and understanding of the spreading of risk-related risks, and the health care services in prisons. This is being done by analysing the views of all actors concerned in order to come to proposals for improvement. Only a comprehensive view on health-care reality in prisons provides the basis for future developments in this area. Health care can be viewed completely different by the different actors involved. Representatives of the prison administration for example might point to certain offers which are not perceived as such by the target group of drug using inmates at all. On the other hand both views might go together quite congruently. As risks related to drug use is a sensitive topic, we chose methods that would reflect the need for anonymity and confidentiality. Focus groups with independent translators, anonymous quantitative methods as well as the views of NGOs might contribute to a complete picture which will be amended by the perceptions and experiences

of prison staff of all levels, representatives of the prison administration and the Ministry of Justice.

This research study wants to bring together countries that reflect (some of the) different legal and penitentiary systems, varying “drug cultures” and levels of HIV/HCV problems among the New Member States, and to find the commonalities and differences that influence the implementation of continuum – of – care approaches towards a healthy prison system. From that (policy) perspective the four chosen countries provide an interesting mix: Estonia, Hungary, Lithuania, and Poland.

The research project is using a triangulation methodology consisting of quantitative, qualitative instruments (including views of prisoners) plus an extensive literature review. All data are taken together in order to better understand health care structures in the specific countries and prisons, to be able to assess gaps and needs, with the final goal to develop baselines for further health care development.

Prison visits took place in eight prisons and one prison hospital. These prisons varied in the type of prisoners accommodated, i.e. males and females, adults and juveniles and pre-trial and sentenced prisoners substantially (see table 2). Within the 4 countries visited there are a total of 269 prisons/penal institutions with a total of 108,473 prisoners in these four countries.

However, the results of this research can not be taken as representative. The prisoners involved mostly were chosen because of a drug use history, and this group is therefore over-represented in order to allow a deep insight into drug-related issues.

Results

This study gives a detailed picture of health status, drug use, health care and drug services in prison in Estonia, Hungary, Lithuania and Poland. Altogether 593 people were interviewed: 490 prisoners in the quantitative survey, 66 participants in prisoner focus groups, 27 experts working in prison and in NGOs (e.g. prison directors, doctors, nurses, social worker) and 10 experts from the Ministries of Justice and/or Prison Administration.

The health status of prisoners is very heterogeneous throughout the four countries studied. The spread of BBV infections varies greatly between countries: 18.7% of the whole sample of 490 inmates in the four countries report a HIV infection and 32.2% a HCV infection (HCV-testing is mostly not

offered). While in Hungary almost nobody reported an infection with HIV or HCV, the proportion in the other three countries is up to 50% for HCV and 40% for HIV. In Estonia in general 14% of all prisoners are HIV positive. Regarding HCV no accurate overview is being elaborated until now, however, study results show that 30% of the sample prisoners are HBV positive and 52% HCV positive. In the majority of the countries visited in this study, rates of drug users, drug injectors and BBV infections (HIV/HCV) in prison populations are much higher than those found in the general population outside of prisons, a fact primarily related to (injecting) drug use and to unsafe injection practices, both in the community and in prisons, and also to unprotected sexual contacts and tattooing in prisons.

Drug use is present in most prisons. For example in Estonia recent data provided by the Prison Department show that 28% among the male and more than 50% of the female prison population are considered to be drug addicts. In Lithuania the number of drug users in prison tripled in the last ten years from 6.6% in 1999 to 20.1% in 2009. According to members of the focus group in Lithuania approx. 50% of all prisoners are users of illegal drugs; "It is quite uncommon if somebody doesn't use drugs". On the other hand Hungary shows a low prevalence of drug users in prisons. However, also in Hungary on a local level data are indicating risk potential (at least in the Budapest Prison), where a recent study revealed that drug use before imprisonment has been stated by 58% of the respondents, daily use of benzodiazepines before by 29% and intravenous drug use before by 33%. In Poland one fifth of prison inmates was considered as drug user, a 2007 survey revealed high life time prevalence of drug use and 6.7 injecting drug use. The study shows that drug use takes place inside prison although to a lesser degree than outside. In Lithuania amphetamines is the most commonly used substance inside prison, while in Estonia benzodiazepines are more common, and the Hungarian sample reports only very little drug use.

The high prevalence of BBV infections in most of the prisons compared to community levels is in itself a massive threat for prison health care. On top of that risk behaviour, especially needle sharing, has been reported in many interviews. If heroin or home-made opioids etc. are used, the drugs are mainly taken intravenously, and up to 15 prisoners are sharing the needle. In Lithuania inmates estimate, that approx. 40 people share one syringe while staff estimates no more than 10 people share one syringe. Syringes are used until they are totally unusable; a new one would cost 6–9 packages of tobacco. Sharpening of the needle is done by using the window glass. Some

prisoners describe the procedure: Those prisoners who are HIV-negative are boiling the needle for some minutes, the rest is sharing. According to the prisoners nobody cares for infections once the drugs are available. Their estimation about the spread of drug users is between 60–80%. Asked if there is a sharing of drugs and injection equipment, prisoners state that everybody is sharing the same syringe as there is just one syringe available. Additional risk behaviour takes place in the prisons to a rather large extent; tattooing is reported by almost half the sample (47.4%), other behaviour is reported less often: sharing a razor blade by 12.5%, and body piercing by 9.1%.

In several countries few special drug prevention units, drug free and/or therapeutic wards have been installed. These units mostly are characterized by better living conditions and insofar are attractive for prisoners to apply for. Better living conditions thus are given as reward for abstaining from drugs.

Measures to control drug use are mainly oriented towards supply reduction and to a lesser extent towards demand reduction. However, the acquisition of drugs in prison is perceived mainly as easy or very easy by 39.5% of the respondents and 60.5% said it's either very or rather difficult.

One important obstacle for not introducing harm reduction measures in prisons is the basic abstinence-orientation to be found in many prison visits throughout the research.

Although there are many (former) opioid users incarcerated, only Poland has introduced Opioid Substitution Treatment (OST) yet (in a few prisons). The basic problem in introducing OST seems to be on the one hand the lack of possibilities to continue treatment after release. On the other hand opioid addicted prisoners often get into the prison institution after they spent days, weeks or even months in police detention where they already run through withdrawal processes.

It became clear that general prison conditions like overcrowding affect the health status of prisoners and are posing serious problems to health care delivery in the sample prisons visited. Thus, reducing overcrowding is at the same time improving living, health and also working conditions for those who have to live and work in prisons.

In several countries visited a discrepancy could be observed in the perceptions of prison health care by prisoners and officials. Whereas 20.6% of prisoners are rating the quality of health care services as rather good or very good, 79.3% as rather bad or very bad. The professionals (doctors, nurses)

often are assessing the quality of prison health care as partly higher than in the community, or as sufficient to meet the health care needs of prisoners.

The services most often desired by the inmates were health education training (44.8%), detoxification with medication (39.7%), individual counselling (38.4%), prison drug services (35.4%) and peer-support (33.9%).

In some countries more confidentiality of drug services has been demanded by prisoners. Especially psychological drug treatments are seen as problematic because prisoners fear that personal and confidential information could be disclosed. Therapy within the closed setting of a prison necessarily leads to problems of confidentiality, mistrust etc.

Physical, sexual, and psychological violence are important issues in the prisons visited. 22.9% of the sample confirms the existence of sexual violence in prison, physical and psychological violence is reported by 50.0% and 66.7% respectively.

In several countries visited the information policy regarding health care delivery, and treatment is perceived by prisoners as insufficient or intransparent (e.g. regarding the provision of pills). This partly leads to mistrust and a negative attitude towards prison health care.

Research is lacking, especially on risk behaviour and longitudinal studies, which bring about more insight into the transition period from prisoner's return into the community. The long-term effects of interventions regarding sustainability are mostly unknown.

Growing expenditures for healthcare in prisons pose enormous threats due to the economic crisis and restricted budgets in the countries visited.

Discussion

Reducing overcrowding affects the health status of prisoners positively and should be initiated and/or maintained in all countries visited.

With regard to decrease of drug use and related infectious diseases, the "Comprehensive Package" provided by the UNODC – as a systematic reaction towards HIV epidemics – needs to be applied in all details in order to make a difference to the current mostly abstinence-oriented approaches.

The 'Comprehensive Package for the prevention, treatment and care of HIV among IDUs' provided by the WHO and UNODC – as a systematic reaction

towards HIV epidemics – is poorly applied in the countries visited. The ‘Comprehensive Package’ includes nine interventions.

1. Needle and syringe programmes: In none of the prisons visited needle and syringe exchange programmes have been implemented or even discussed.
2. Opioid substitution treatment (OST) and other drug dependence treatment: Despite all efforts in the countries visited the reactions towards the high burden of health challenges need to be scaled up with more speed and intensity. The evidence-based drug intervention strategy of pharmacotherapy with methadone or other agents needs urgently to be either introduced or increased to reach a higher coverage. The majority of prisoners interviewed was in favour of an introduction of OST, especially for detoxification purposes. At the moment drug addicted opiate users entering prison experience severe withdrawal symptoms in the institution. Often detoxification is not done state of the art, instead a symptomatic treatment is performed by using painkillers, benzodiazepines and sleeping pills. Furthermore prisoners interviewed are demanding “therapy instead of punishment”, which would allow them to get out of prisons earlier and go instead into therapeutic institutions. Both pharmacotherapy and abstinence-based approaches are important elements of drug treatment and pre-release treatment. Special approaches for women are needed as the spread of drug addiction and HIV is extremely high in this most vulnerable population. OST is definitely needed as a means of detoxification first.
3. HIV testing and counselling: Furthermore more attention has to be paid to the spread, prevention and treatment of hepatitis B and C. Especially the policy and practice of HCV-tests and diagnosis need to be developed, HCV-testing should be recommended to all prisoners and should be part of the general medical examination on entrance. HCV-therapies – although expensive – have to be provided, as compliance of drug users to HCV therapies is comparable with other HCV-infected patient groups. In two of the countries (Hungary and Lithuania) HIV positive prisoners are either separated or are sent to specialist prison centres for better control, monitoring and treatment. This might be problematic in terms of disclosing the HIV status and in Lithuania produces fears simply because of being transferred to a prison far off.

4. Antiretroviral treatment (ARV): Antiretroviral treatment is implemented in the four countries, but not always offered to all those infected. Especially prisoners in ARV treatment often don't feel informed and educated about side effects. If the doctor is informing about ARV treatment often this is not understood correctly by the prisoners, who then need a 'translation'. According to prisoners the adherence to the therapies would be higher if patients would understand purpose and goal of the treatment. This partly leads to mistrust and a negative attitude towards prison health care.
5. Prevention and treatment of sexually transmitted infections (STI): This does not seem to be an important issue in the prisons visited.
6. Condom programmes: The provision of condoms is handled differently. Condoms are sometimes available at the prison shop, sometimes at the medical ward, and in some prisons condoms are only available in long term visit rooms. Usually condoms are not accessible in common areas for easy and confidential access.
7. Targeted information, education and communication: Information, communication, and education means and strategies have to be developed specifically for the different target groups in order to get the preventive messages and information across. Unspecific material and messages might get lost or do not have the impact expected.
8. Vaccination, diagnosis and treatment of viral hepatitis: HBV-vaccination is often offered only for members of risks groups (e.g. in Estonia for prisoners with more than 7 months imprisonment). Hepatitis C treatment is offered in some cases.
9. Prevention, diagnosis and treatment of Tuberculosis: Tuberculosis screening is done to large extends in the Hungarian and Polish sample prisons, where few prisoners refuse the test. It is offered as well in Lithuania and Estonia, especially to high-risk groups. TB-treatment is often done in the prison hospital.

Programmes against physical, sexual, and psychological violence have to be developed in order to reduce health risks for all prisoners.

Other future challenges are treatment forms for the increasing number of poly-drug users and sufficient prison-community linkages to establish sustainable pathways of throughcare.

1 Introduction

With the enlargement of the European Union, the EU now includes 27 legal and penitentiary systems and even more due to the fact that some federally organised countries have different legal and justice structure across their 'Länder', cantons and Autonomous Regions.

Aims and objectives

The so called New Member States are currently in the process of reform towards EU and international standards, also in the areas of legislation, drug policy, drug treatment and imprisonment. Despite efforts aimed at reform, law enforcement and incarceration remain the dominant approaches towards the problem of problematic drug use in these countries. While most New Member States have, to varying degrees, implemented more effective treatment programmes and harm reduction projects outside of the prison system, effective drug treatment and BBV prevention programmes within the prison walls and follow up services for released inmates with problematic drug use have, in most new Member States, yet to materialise. Overall, prison policies and practices, in particular in dealing with drug users, remain an important EU concern. In few of the new Member States the public health imperative of a healthy prison system receives the political attention it deserves. In many countries, prisons can still be described as: "foci for the development of high levels of drug-resistant communicable diseases."

The objectives of the study are operationalised into concrete questions on (i) prevalence, (ii) nature and severity, (iii) characteristics and correlates of problematic drug use, including risk behaviours for HIV and other infectious diseases, (iv) need for care and treatment services and available support systems. The study also assesses differences in prevalence, nature, characteristics and need for services associated with gender and ethnicity.

2 Methodology

The focus of this study was to collect data on and therefore increase knowledge and understanding of the spread of drug related risks, and the health care services in prisons. This is being done by analysing the views of all actors concerned in order to come to proposals for improvement in the end. Only a comprehensive view on health care reality in prisons is providing the basis for future developments in this area. Health care can be viewed completely different by the different actors involved. Representatives of the prison administration for example might point to certain offers, which are not perceived by the target group of drug using inmates at all. On the other hand both views might go together quite congruently. As risks related around drug use is a sensitive topic, we chose methods that would reflect the need for anonymity and confidentiality. Focus group interviews with independent translators, anonymous quantitative methods as well as the views of NGOs might contribute to a complete picture, which will be amended by the perceptions and experiences of prison staff of all levels, representatives of the prison administration and the Ministry of Justice.

2.1 Study Site Selection

This research study wants to bring together countries that reflect (some of the) different legal and penitentiary systems, varying “drug cultures” and levels of HIV problems among the New Member States, and to find the commonalities and differences that influence the implementation of continuum of care approaches towards a healthy prison system. From that (policy) perspective the four countries chosen provide an interesting mix.

Estonia and Poland have a tradition of home-made opiate drugs (Cheornaya, Kompot), but after the political changes, both a rapid increase in the prevalence of injecting and a transition to powder heroin has been observed. On the other hand, in Hungary and Lithuania homemade opiates have never reached the level of popularity found in Estonia, Poland and the former Soviet Union. In Lithuania amphetamines are and remain the most widely injected drugs, while, after the political transition, Hungary experienced a significant heroin problem, with Budapest as the epicentre, but all larger cities affected.

These countries also represent different stages in both HIV epidemic development and response to it. Poland has experienced a significant HIV epidemic among IDUs in the 1980s. Estonia now has the highest HIV prevalence in the EU, almost exclusively associated with IDU. While they host significant populations of drug injectors, Hungary and Lithuania have yet been spared large outbreaks of HIV among their drug injecting populations (although there was a HIV outbreak in a Lithuanian prison, Alytus prison, five years ago).

2.2 General methodological approach

The research project “Towards a continuum of care in the EU criminal justice system – a survey of prisoners needs in four countries (Estonia, Hungary, Lithuania, Poland)” is using a triangulation methodology consisting of quantitative and qualitative instruments plus an extensive literature review. All data are taken together in order to better understand health care structures in the specific countries and prisons, to be able to assess gaps and needs, with the final goal to develop baselines for further health care development.

The study includes six levels:

1. A study of relevant scientific literature, including existing information systems, to generate first estimates of problematic drug use prevalence, behavioural correlates and treatment in prison.
2. To get an overview of the specific country situation of drug use, risk behaviour etc. interviews are carried out with representatives of the Ministries of Justice, resp. national prison administrations. The interview checklist contains questions relating to the relevant areas of prison policy and practice. The results will go into a country report which is dealing with the background information.
3. Interviews with the representatives of the prisons selected. These are governors, head of medical units, doctors, nurses, social workers, psychologists active in the field, in order to get an overview of the specific prison situation (which offers are made, what is their impression of drug use and risk behaviour in prisons, how do they perceive or even incorporate prisoner’s health needs and in particular needs related to avoid drug use and risk behaviour. In addition, in order to get comparable statistical data from each of the sample countries detailed data were collected at the time of the visit to the central prison administration.

4. Interviews with representatives of supporting NGOs working in the relevant field.
5. A survey of drug using prisoners. Respondents will be assessed for drug problems, behavioural correlates, service needs and experiences, and substance use inside/outside of prison. To that purpose dedicated instruments have been designed, based on the research questions of the study, using, where possible, existing and validated instruments, consulting the instruments of previous studies and other prison survey instruments. The research involved visiting at least two prisons in each of the four countries. The two prisons chosen are covering a mix of women and men, short and long term prisoners. A sample of approx. 100 drug using inmates in each participating country has been given the self-administering questionnaire. Additionally in each of the prisons one focus group of up to 10 prisoners has been organised with key informants with whom health needs and services have been discussed more in-depth. Women are over-sampled to reach statistical power for the gender analysis. The use of these methodologies will result in a robust database. Using standard statistical software (SPSS 11.5), the analysis will consolidate the various data sources. In the end prisoner needs profiles will be constructed.
6. A Meeting on 'Matching Needs and Services' was finally held in each of the respective countries (except Poland) in order to discuss how to fill the service gaps arising from the empirical work. These meetings were organised with representatives of the Ministries of Justice, prison organisations, University of Applied Sciences, Frankfurt, national partners and NGOs. The goal was to identify ways of improvement of the health situations. The researchers at the meeting assessed care and services needs, present these in care need categories and make recommendations for service development and coordination.

2.3 Project management

The study has been coordinated first by the University of Bremen and later by the University of Applied Sciences, Frankfurt (both Germany) with the support of country coordinators (local researchers) (see table 1).

Table 1 Country coordinators

Country	Organisation and names of coordinator
Estonia	University of Tartu
	Anna Markina
Hungary	Changing Lanes / Váltó-Sáv
	Meszaros Mercedesz
Lithuania	Prevention Centre/ Prevencijoscentras
	Janina Kulsiene
Poland	Jagiellonian University, Association of Alumni and Friends of the Law and Administration Faculty at the Jagellonian University
	Prof. Dr. Krzysztof Krajewski Alicja Papierz Maria Stozek

University of Bremen resp. University of Applied Sciences, Frankfurt staff conducted the literature review and coordinated national input; developed all instruments and reporting formats; provided training on study implementation to local researchers; conducted overall qualitative and quantitative data analysis for the study; conducted two site visits to each study site; and produced the final research report and other deliverables, as described below.

Local in-country researchers were chosen to support the project implementation in each country and to coordinate the study in the respective country. They are experienced researcher in the field of prison studies and the expertise required for the coordination and supervision of the local data collection efforts. They have been developing and maintaining the necessary contacts with prison authorities and secured the required permissions to work within prison facilities; their fieldworkers had access to selected prison facilities and were able to build contact with drug using inmates.

The selected researchers were involved in the collection of data at a national level. They have:

- collected and compiled (and where necessary translate) national literature and data for the literature review;
- developed and maintained the necessary contacts with prison authorities and secure the required permissions to work within prison facilities;
- co-developed and implemented the (national) sampling strategies,

- arranged for and participated in data collection on levels 2,3,4, and 6
- arranged for, conducted and supervised the collection of the survey data;
- participated in the analysis and interpretation of the national sub studies; and,
- participated in the Meeting on Matching Needs and Services.

2.4 Details of institutions visited and participants interviewed

2.4.1 Field visits

Table 2 Details of the prisons visited in the sample countries

Country	Prisons visited	Type	Category of prisoner
Estonia	Harku	Females	120 sentenced prisoners
	Tallin	Adult males	670 sentenced prisoners
Hungary	Budapest	Adult male	1,200 sentenced prisoners
	Kalocsa	Females	269 sentenced prisoners
Lithuania	Vilnius Correction House (number 2)	Adult male	477 sentenced prisoners
	Panevezys	Female	295 Sentenced prisoners
Poland	Slucevicsz	Adult male	850 sentenced prisoners
	Lubliniec	Adult male	227 remand, sentenced, half-open
	Mokotov Prison Hospital	n.d.a.	n.d.a.

n.d.a. = no data available

In each country NGOs and governmental organisations were visited.

Prison visits took place in eight prisons and one prison hospital. These prisons varied in the type of prisoners accommodated, i.e. males and females, adults and juveniles and pre-trial and sentenced prisoners substantially (see table 2). Within the 4 countries visited there are a total of 269 prisons/penal institutions with a total of 108,473 prisoners in these four countries. Taking this background into consideration, clearly this study can only offer a snapshot of health care services available in prisons in these countries. In addition, this research is not intended to be comparative or representative, due to the differences in the way prisons are being run in each country and also in the legislation used to deal with problematic drug use. The selection of national prison administration, individual institution and non-governmental

organisation staff was dictated by the need to interview participants with specific roles and responsibilities. For the focus groups, this process was generally based on availability of prisoners and their suitability in relation to experience with problematic drug use. The field visits across the four countries were conducted between October 2008 and February 2009, with each visit lasting three to four days, depending on the geographical location of the prisons and the agenda prepared by the country contact.

Table 3 NGOs visited in the 4 sample countries

Country	NGOs and Governmental organisations visited
Estonia	Convictus
Hungary	Changing Lane
Lithuania	Peer-Support Group Vilnius, Anonymous Alcoholics Panevezys
Poland	Monar Poland

2.4.2 *Inmates' survey*

The self-administered questionnaire was handed to a sample of at least 100 (drug using) inmates in each participating country. The introduction of this questionnaire has been done by NGOs (Hungary, Estonia, Lithuania) and researchers (Poland) in order to guarantee confidentiality. The prisoners have been informed of the character and nature of the study and that their participation was acknowledged but absolutely voluntary. They could stop their participation at any given point.

The questionnaire consisted of 38 questions in the following areas:

- Socio-demographic data
- Length and frequency of imprisonment
- Assessment of own health status
- Availability and access to treatment
- Service needs
- Experiences with services in the community
- Drug use and mode of administration
- Risks associated with drug use and imprisonment

The questionnaire has been translated into the respective languages in each country, furthermore a Russian version has been elaborated. The question-

naire has been adopted to the country specific situation (with respect to language, terms, culture).

The quantitative survey took place between November 2008 and April 2009¹.

2.4.2.1 Estonia

The survey was conducted in four Estonian prisons: Harku, Tallin, Tartu and Viru between April 1st and May 14th 2009.

Harku Prison is a closed prison for convicted females with a maximum of 166 inmates, located on the outskirts of Tallin. There is a separate department for mothers with children up to the age of four, and a rehabilitation ward with eight places for inmates with drug addiction problems. In 2008 there were 119 inmates in Harku Prison.

Tallin Prison is a maximum-security prison with cells for adult males and females held in custody and for convicted men. The maximum number of inmates is 1,179 – in 2008 there were 1074 inmates.

Tartu Prison is a maximum-security prison with cells for adult males and females held in custody and convicted men with a maximum of 924 places. In 2008 there were 907 inmates.

Viru Prison is a maximum-security prison founded in 2006 for adult males being held in custody and convicted adult and young men. Of the 1,000 places 250 are for the juveniles, this being the only prison for juveniles. The first inmates came in April 2008, in October there were 948 inmates.

2.4.2.2 Hungary

The survey was conducted in four Hungarian prisons between November 13th 2008 and February 16th 2009. As in Hungary not a sufficient number of questionnaires were handed back from the first two prisons visited, research has been expanded to other prisons in order to reach the minimum of 100 questionnaires.

The four prisons are:

- Budapest prison has 1,018 places for prisoners but held a total of 1,506 in 2008, both sentenced and pre-trial, for predominantly men and a few women.

1 questionnaires can be obtained by the authors

- Kalocsa is a women prison with 240 places and 282 inmates in 2008.
- Marianosztra is a men's prison with 444 places which were occupied by 521 prisoners in 2008.
- Balassagyarmat is a men's prison with 321 places and 449 inmates in 2008.

So overcrowding is an issue in each of the sample prisons (see chapter 2.4.2.2).

Although it was intended to perform the survey among drug using inmates, not in all cases a sufficient number of drug users could be found in Hungary, therefore non-drug users are included as well.

2.4.2.3 Lithuania

The survey was conducted in two Lithuanian prisons on the 7th and 8th of April 2009. Vilnius Corrections House 2 (V2PN) is a prison for adult men with 471 prisoners on January 1st, 2009. Panevezys Correction House (PPN) is a prison for adult and juvenile sentenced women. There were 295 prisoners on January 1st, 2009. The survey was conducted on April 7th (men's prison) and April 8th (women's prison) 2009.

2.4.2.4 Poland

The survey was conducted in four prisons in Poland between January, 30th 2009 and February 6th 2009.

- Warszawa-Sluzewiec remand prison for first-time inmates and juveniles. It has about 850 places and 42 places in the drug therapy unit.
- Wroclaw prison also is for first-time sentenced and juveniles. The prison has a capacity of 1384 places and 45 in the therapeutic unit.
- Rzeszow prison is for recidivist inmates. It has 997 places and 40 in the therapeutic unit.
- Lubliniec is a women prison with 227 places and 35 in the therapeutic unit.

The survey in all four prisons was conducted in the drug therapy units. At some points when filling in the questionnaires the prisoners would talk loudly to each other and comment on single issues. Therefore especially for delicate questions concerning infectious diseases, sexual contacts and opiates dependency (as opiate addicts being at the bottom of the prison's subcultural hierarchy), answers could be influenced by these not completely anonymous cir-

cumstances. In one prison the questionnaires were completed in the presence of the prison's therapists.

2.5 Procedures and ethical issues

Prisoners were asked highly sensitive questions (drug using careers both in the community and possibly during their imprisonment and what harm reduction measures they had access to both in the community and in prison). As drug use, tattooing, and sexual activity can be treated as 'disciplinary behaviour' guaranteeing confidentiality plays a major role. In parts also staff and head of services were asked sensitive questions, as their answers might get into conflict with professional and/or political views and perceptions of the problems.

Because of these reasons it is important for the research to be underpinned by clear ethical guidelines for the protection of both the participant and the researcher. This research followed the ethical guidelines provided by the British Sociological Association, which includes informing all participants that their responses would be treated confidentially, and that they were free to withdraw their participation at any time.

The following information is provided to ensure that ethical and confidentiality guidelines are adhered to during the course of the research.

1. Drug users in custody focus groups
 - i) There should be no more than 10 (former) drug users in a focus group;
 - ii) The focus group will last no longer than one and a half hours;
 - iii) The researcher and interpreter should be allowed to run the focus group without the presence of any prison staff (this is important to allow prisoners to speak freely about sensitive issues like drug use);
 - iv) The focus group should take place in a room where the discussion can not be overheard and thus ensure confidentiality;
 - v) The subject of the focus group should be made clear to the prisoners. They are asked if they wish to participate and they are told that they are free to leave at any point during the focus groups;
 - vi) The prisoners are told that anything they say during the focus group will be confidential and that they will not be named in the end report of the research.

2. In-depth Interviews with prison staff
 - i) The interviews should take no longer than 30–45 minutes with each participant;
 - ii) The researcher and interpreter should be allowed to interview respondents individually (There may be occasions when it is appropriate to talk to a group of staff working in a particular department in the prison and this can be negotiated in each prison in the sample);
 - iii) The interviews should take place in a room where the discussion can not be overheard and thus ensure confidentiality (It is often helpful if the interviews can take place in the area of the prison where the respondent works both for the quality of the discussion and to avoid staff waiting around for a previous interview to finish);
 - iv) Staff are told that anything they say during the interview will be confidential and that they will not be named in the end report of the research;
 - v) All respondents are asked if they wish to participate in the research and that they are free to discontinue the interview if they wish so.

2.6 Methodological issues arising from the fieldwork

In some prisons it was necessary to renegotiate that the focus groups should be held only with prisoners and researchers. Although the independence of the translator was a prerequisite for the empirical work, this could not be achieved in the Kalocsa prison in Hungary. There we were not allowed to conduct the study unless we were integrating an educator who spoke perfectly German as a translator. Due to time constraints individual interviews with prison staff were not always possible rather a small group of staff were interviewed together, which could be problematic if the staff present had very different roles and priorities. Some prisoners in the focus groups had not previously been drug users and as such had limited knowledge of drug use although they were aware of what harm reduction tools were.

2.7 Definition of key terms

Harm Reduction

In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs. A “harm reduction approach” recognises that a valid aim of drug interventions is to

reduce the relative risks associated with drug use, from reducing the sharing of injecting equipment, through to stopping injecting, substitution treatment for heroin users and abstinence from illegal drugs. Most harm reduction interventions specifically aim to prevent blood-borne diseases (most particularly HIV and hepatitis infections) and other drug-related harm, including overdose and drug related death. All drug treatment services, residential or community-based, should provide a distinct harm reduction element to reduce the spread of blood borne viruses and risk of drug-related deaths in the treatment they provide. Specific harm reduction interventions to reduce the spread of blood-borne viruses and reduce overdose include:

- Needle exchange services i.e. the provision and disposal of needles and syringes and other clean injecting equipment (e.g. spoons, filters, citric acid) in a variety of settings.
- Advice and support on safer injection and reducing injecting and reducing initiation of others into injecting.
- Advice and information to prevent transmission of BBVs (particularly hepatitis A, B and C and HIV) and other drug use-related infections.
- Hepatitis B vaccination.
- Access to testing and treatment for hepatitis B, C and HIV infection.
- Counselling relating to HIV testing (pre and post test).
- Advice and support on preventing risk of overdose.
- Risk assessment and referral to other treatment services.

Harm reduction interventions such as needle exchange, advice and information on safer injecting, reducing injecting and preventing overdose should also be available as open-access services in each local area. Needle exchange services often have contact with problematic drug users who are not in touch with structured drug treatment services. Harm reduction interventions should be integrated into all drug treatment service specifications via contracts or service level agreements and also into structured drug treatment according to an individual client's needs (National Treatment Agency for Substance Misuse, 2005).

A status paper on prisons and public health related to drugs and harm reduction defined harm reduction measures in prisons as:

“A concept aiming to prevent or reduce negative health effects associated with certain types of behaviour (such as drug injecting) and with imprisonment and overcrowding as well as adverse effects on mental health” (WHO Regional Office for Europe, 2005: 5).

The concept of harm reduction acknowledges that many drug users cannot totally abstain from using drugs in the short term and aims to help them reduce the potential harm of drug use. In addition, the definition the WHO acknowledges the negative health effects imprisonment as such can have, which include the impact on mental health, the risk of suicide and self-harm and the need to reduce the risk of drug overdose on release. It also emphasises the more general harm resulting from inappropriate imprisonment of people requiring facilities unavailable in prison, especially in those which are overcrowded.

Problematic drug use

Problematic drug use (PDU) is defined as “injecting drug use or long duration/regular use of heroin/cocaine and/or amphetamines” (EMCDDA, 2006). This definition can also include other opioids such as methadone. Furthermore, drug consumption is deemed to be problematic, if this behaviour is joined with other risk behaviour, causes damage to other persons or produces negative social consequences (EMCDDA 2005). The latter is not clearly defined. Although no clear definition of negative consequences can be found in the literature, it can be said, that negative social consequences are frequently linked to offending, be it a direct cause such as theft to fund drugs or a contributory factor such as violent crime fuelled by excessive alcohol use. In most countries PDU is understood as distinct from recreational or experimental use, in that it often leads to harmful consequences. Polydrug use needs to be distinguished from PDU, because it describes the “...frequent use of more than one substance over a minimum of specified time period...” (EMCDDA, 2006: 92). Recently there has been a debate about this topic, due to the spread of polydrug users and the therewith involved problems within the monitoring system (EMCDDA, 2006).

3 General problems in prison health care delivery – results of the literature review

3.1 Structures and problems of organisation of health care: Prison as a high risk environment

The specific prison situation raises a number of problems and questions concerning health care. These include questions of confidentiality, professional independence, the missing right to choose a doctor, medical staff being employed by the prison administration, probably medical staff being employed for security tasks, prisoners might use the doctor to make prison life easier, and restricted budgets for prison health care (see Pont, 2006). The principle of confidentiality, privacy and consent might conflict the principle of security and safety as the first objective in prison, while the professional independence of the medical staff might be regarded as restricted when they are employed by the prison administration (Pont, 2006: 260).

Tasks like body searches and drug testing for security reasons should not be performed by the doctor responsible for the prisoner's treatment. Doctors should not be present during physical punishment or capital punishment (Pont, 2006: 263).

3.1.1 Overcrowding and over-representation of risk groups

Overcrowding implies health risks like insufficient airing, light, and space. Furthermore it can enhance the transmission of infectious diseases like TB, and not least stress and mental problems arising from the situation have to be taken seriously in the discussion.

Certain groups are over-represented in prisons around the world. Prison inmates often belong to the poor and marginalized part of the population. Drug users are a large group in the prisons around the world, and partly connected with that, infectious diseases are over-represented among the prison population.

3.1.2 The principle of equivalence for health care in prisons

The Council of Europe states the equivalence of health care in recommendation Rec (1998)7 (Elger, 2008:195). The principle of equivalence for health care in prison implies that the quality, extend und supply of health care in

prison should be comparable to the health care in the community of the respective country. This principle is addressed in a number of international rules, guidelines and recommendations (see chapter 3.6) and has broad consensus (see e.g. Lines, 2006);

- prisoners might need more, as they are more affected, more ill
- the principle is stated in many international guidelines (see chapter 3.6) and in National laws as well,
- in reality, the principle is often not fully implemented.

It is argued, that prison healthcare needs to be superior to community health care as a consequence of the responsibility for prisoners, who have no other possibilities, also when community health care is poor (see penal reform int. in Pont, 2006). Lines argues that the equivalence of health care is not enough, even though most countries don't achieve this standard, and that the equivalence of objectives would be the better standard looking at the unique and often extreme health problems in prisons. The higher standard needed in prison is necessary as to ensure the health of the prisoners. Lines argues with methadone maintenance treatment as an example, where enhanced treatment access in prison would be necessary in order to achieve the objective of this treatment – reducing injecting and the risk of HIV and hepatitis transmission. Therefore Lines argues that the principle of equivalence is only a minimum standard. Due to imprisoning people the state has a higher responsibility to maintain their health and therefore provide better care than outside (Lines, 2006). As the prisoners' well-being is dependent on the state, the latter is responsible for the health of the prisoner more than in the community. Also the European convention states a right to health for persons in prisons but does not for European citizens generally (Lines, 2006: 275f.). Both from the perspective of public health and human rights the principle of equivalence is not sufficient, enhanced services and standards might be needed (Lines, 2006: 277).

In the Canton of Geneva, Switzerland, prison medical care is based on the principles and standards of the CPT Council of Europe recommendations, which was facilitated through several factors: Institute of Legal Medicine leaders interested in prison health care, engagement of them with CoE level and therefore direct exchange, university-based provision of health care for prisoners, significant influence of directors of Institute for Legal Medicine due to their expertise, and Geneva as a city with a humanitarian "spirit" and many Human Rights organisations (Elger, 2008: 197).

3.2 High risk behaviour in prisons

There are numerous studies which demonstrate that custodial settings are facing increasing problems with drug use, sexual activity, tattooing/body piercing and other high risk behaviours. This is not only posing a security threat to prison management, but often also results in serious health damages for prisoners (Jürgens et al., 2009; Lines et al., 2005b; MacDonald, 2005; Pallas et al., 1999; Polonsky et al., 1994; Schulte et al., 2009; Stöver, 2002; Stöver et al., 2008). In addition, drug users are among the most vulnerable prisoners, and are worldwide over-represented within the prison population, often due to a growing trend towards the criminalization of drug use and possession and the use of custodial sentences for drug-related crime, throughout the EU (EMCDDA, 2003) especially among young people (Muncie, 2005).

The risks associated with injecting drug use present clear threats to prison health care services, and consequently to public health services (Ramsay, 2003). Drug using prisoners on short term sentences pose a particular problem, as they are unable to access treatment programmes and return to their families and communities with communicable diseases contracted in the prison, putting them at additional risk (WHO Regional Office for Europe and Pompidou Group of the Council of Europe, 2001). There are clearly identifiable dangers of high risk behaviour (e.g. sharing of injection equipment, unprotected sexual contacts; and tattooing/piercing) in prisons, as needles and syringes are not available and sexual activity is either ignored or denied completely. Syringes are contraband and thus scarce in the prison setting, and sexual relationships are a taboo.

There is a clear need for prison systems throughout the EU to acknowledge risk behaviour in custodial settings (use of drugs, sexual activity, tattooing/piercing) in order to prevent prison health problems becoming public health problems (Ramsay 2003). In addition, preventive measures will be ineffective, if national prison administrations continue to refuse to acknowledge the widespread health risks of prisoners.

3.2.1 *Nature and prevalence of drug use and related risks*

Despite many control efforts illicit drugs get into custodial institutions and prisoners consume them. Just as in the community, drugs are present in prisons because there is a demand and a market for them and because there is money or other goods or services to exchange. Many prisoners have a history of drug use or are actively using drugs at the time of incarceration. As such,

drug users form a particularly over-represented group in the prison population in many countries. A typical profile for the group of drug users finally ending up in prison would include the following characteristics: socially deprived, poly-drug users with several stays in prison, having experienced several treatment attempts with a high incidence of relapse and with severe health problems, including incurable infectious diseases and mental illness (Stöver, 2001).

The number of drug-law offences in most EU countries has risen constantly over the past 15 years. As a result, the number of drug users in prisons has increased substantially (Stöver et al., 2008).

In addition to those people who enter prison with a history of, or active, drug use, a substantial proportion of prisoners start using drugs while in prison as a means to release tensions and to cope with living in an overcrowded and often violent environment (Taylor et al., 1995).

Prevalence of drug use

There are various indicators of the extent of drug use in a prison, e.g. drug-seizure quantities, discovery of needles/syringes, positive drug tests among prisoners and official statistics of known and sentenced drug users. Using such indicators alone may ultimately reflect only a part of the actual situation, and therefore provide an incomplete picture of the full extent of drug use, types of drugs used and routes of administration in prisons. Scientifically acquired data such as prevalence studies, while useful, may reflect the situation in no more than one single prison. Due to the changing nature of the population from one prison to another and from region to region within a country, these isolated cross-sectional studies cannot be taken as representative of the situation as a whole.

Drawing a detailed picture of drug use in prisons is difficult in a particular country, and even more so across the EU. Qualitative studies focussing particularly on drug use patterns in prison are lacking. Drugs used and patterns of drug use vary considerably between different groups in the prison population. For instance, drug use among women and juveniles differs significantly from that among men, with different levels and types of use and different motivations and behavioural consequences. Common factors are scarcity of drugs, extreme secrecy, black markets and trafficking within custodial settings.

However, the range of drug use experience among prisoners can be drawn from some studies. The average percentage of drug offenders in the European Union is 18.5% (Council of Europe, 2004), with particularly high rates in Greece (63.0%), Italy (29.4%), and Norway (29.1%) (Council of Europe, 2007). In Eastern European countries like Bulgaria and Romania the number of inmates due to drug offences is of minor relevance (Council of Europe, 2007).

Globally the prevalence rates of psychotropic substance use and dependence in prisons were found to be up to ten times higher among prisoners than in the general population, ranging from 10% to 48% in male inmates and 30% to 60% in female inmates (Fazel et al., 2006). In 2006, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2006) estimated the lifetime prevalence rates of injecting drug use (IDU) among prisoners in Europe at 7% to 38%, the prevalence rates of prisoners injecting drugs in prison at 1% to 15% with great differences between prisons (EMCDDA, 2006). Though some studies indicated less frequent IDU in prison than in the community (e.g. Dolan et al., 1996; Shewan et al., 1996), other experts estimated that up to 75% of the inmates with a history of IDU continue drug use in prison (Lines et al., 2005a; Stark et al., 2006; Stöver, 2002), and up to 25% of injecting drug users (IDUs) started injecting while in prison (Gore et al., 1995). For Germany, experts estimate that up to 50% of the inmates in German prisons have experience with illicit drugs (mostly cannabis), and at least 25% must be considered as 'problematic drug users' (PDUs). Radun et al. found in their cross-sectional study in six German prisons a weighted lifetime prevalence of IDU of 29.6% (n=464) among 1,497 prisoners (Radun and et al., 2007). The German Federal Ministry of Health estimates that approximately 10,000 IDUs were incarcerated in German prisons in 2003, without specifying whether they were current or former IDUs (Bundesministerium für Gesundheit, 2003).

Patterns of drug use vary considerably between different groups in the prison population, and between prisons in the same region: Juvenile prisons, women's prisons and prisons with a high percentage of foreign prisoners may have totally different drug use prevalence figures. Studies indicate that prison reception screening consistently underestimates drug and alcohol use and in many cases in which substance use is identified the quantities and numbers of different substances being used are underestimated (Lines et al., 2004).

In addition to illegal drugs, legal drugs (nicotine and tobacco, alcohol and prescribed pharmaceuticals) often contribute to the addiction and health problems of prisoners. Many prisoners have a long history of regular use of legal drugs and multiple drug use is widespread throughout the EU, particularly among young people (EMCDDA, 2003).

In summary, drug use is seen as one of the main problems of the current prison systems with effects on security measures and on the relationships between prisoners and staff (Restellini, 2007). More and more it is accepted that drug use is a common activity in prisons around the world. According to UNAIDS: “Whether the authorities admit it or not – and however much they try to repress it – drugs are introduced and consumed by inmates in many countries ... Denying or ignoring these facts will not help solve the problem of the continuing spread of HIV” (UNAIDS, 1997: 3).

Studies have also highlighted incidences of prisoners switching to other drugs, which are easier to obtain, have stronger effect or are more difficult to detect in urine or blood. For example, the introduction of mandatory drug testing in prisons led prisoners to use opiates over cannabis which stays in the bodies’ system for up to a month, whereas opiates can become undetectable within a couple of days (Edgar and O’Donnell, 1998; MacDonald and Harvey, 1997).

The reasons given by prisoners for using drugs during their sentence include to relieve boredom, to cope with stress and crisis that occur such as sexual or physical violence (Marshall et al., 1999). Therefore prison itself can lead to prisoners continuing to engage and, in some cases, starting to use drugs (EMCDDA, 2005).

For some prisoners, their sentence is seen as a time of abstinence, to help them recuperate from the damaging effects of using drugs, though this may just be a temporary reprieve. This often occurs in conjunction with a general improvement in their health, as often, prison drug treatment is the first time many users come into contact with any sort of support. It is also evident that on release, with a lack of support in the community, many users continue or restart their drug use (Turnbull et al., 1991).

Sharing injecting equipment and spread of BBVs

Although injecting drug users are less likely to inject while in prison, those who do are more likely to share injecting equipment and with a greater number of people, as they have no longer access to clean equipment within the

prison (Lines et al., 2004). Studies have shown the impact of not providing such services, as in 1993, in the first documented outbreak of HIV, 43% of prisoners reported that they injected drugs and shared equipment (Taylor and Goldberg, 1996). A substantial number of drug users report having first started to inject while in prison. Studies of drug users in prison suggest that between 3–26% first used drugs while they were incarcerated and up to 21% of injectors initiated injecting whilst in prison (EMCDDA, 2003).

Blood borne infections (e.g. HIV, hepatitis B and C) that are transmitted among drug users by unsafe injections, sexual practices, tattooing and piercing are massively over represented in prisons compared to the community (CEEHRN, 2007; Laticevschi, 2007). The prevalence of drug use and sharing injection equipment among incarcerated women is higher than among incarcerated men (Stöver and Lines, 2006). Juveniles and migrants are at particular risk as they often have a poor understanding of the nature and character and the dynamics of infectious diseases in closed settings (MacDonald et al., 2007).

Injecting drug use also puts prison staff at additional risk, for example needle stick injuries during cell searches (Bögemann, 2007).

3.2.2 *Unprotected sex*

Unprotected sexual contacts between prisoners pose a risk for the sexual transmission of HIV, hepatitis and other sexually transmitted diseases. Within penal institutions, sexual contacts occur in different ways, and in varying frequencies. Sex may be consensual, or it may be forced or coercive. Sex may also be used as a form of currency within the prison and exchanged for money, protection, property, or drugs. Violent forms of unprotected sexual anal or vaginal intercourse, including rape, carry the highest risk for transmission HIV, particularly for the receptive partner who is more likely to suffer damage or tears in the membranes of the anus or vagina (Betteridge and Jürgens, 2004).

Same-sex sexual activities are the most common forms of sexual contacts in prisons. Although homosexuality has been decriminalised in many countries, significant stigma is still attached to same-sex sexual activities (particularly male homosexuality) in many societies and in many prison systems. This stigma can lead to discrimination by other prisoners and staff members. Men having sex with men in particular may be subject to violence, discrimination, and social exclusion. These negative consequences can make sexually active

male prisoners even more vulnerable to HIV infection by deterring them from accessing safer sex measures such as condoms (in prisons that provide them) for fear of identifying themselves as sexually active. Many prison systems maintain prohibitions against any sexual activity (whether consensual or non-consensual) that can also create barriers to prisoners accessing safer sex measures such as condoms.

The prevalence of sexual activity in prison is influenced by factors such as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification, and the extent to which conjugal visits are permitted. Given the stigma in most societies against same-sex sexual relationships, levels of sexual activity among prisoners are difficult to estimate with any accuracy as these relationships (whether consensual or forced) generally occur in secrecy. Risk behaviour studies within prisons may also under-record the true amount of sexual activity, as many prisoners may be reluctant to disclose same-sex sexual behaviours to researchers. Dumond (2006) found that only a small minority of victims reports rapes to prison authorities (96 of 2,000 rapes reported): “In some ways, the victim is in a nowin situation” (Dumond and et al., 2006: 5). Only a few percent of correctional officers charged with direct supervision believed that rape was a rare occurrence. Staff may respond poorly or blame the victim (Jürgens 2006).

That said several studies have provided evidence that significant rates of risky sexual behaviour occurs in correctional settings. Studies of high – risk behaviour show widely varying estimations of the proportion of male inmates who have sex with other men (see Okie, 2007). They range from 2 to 65% and estimations of the proportion of those who are sexually assaulted range from 0 to 40% (Krebs, 2006). A study conducted among 373 male prisoners at all of South Australia’s prisons (Gaughwin et al., 1991) concluded that 12% engaged in anal intercourse at least once. Another study in South Australia (Douglas et al., 1989) reported that prison officers and prisoners estimated that between 14% and 34% of prisoners engaged in ‘occasional anal intercourse’. The European Network on HIV/AIDS and Hepatitis Prevention in Prison found rates for sexual intercourse among men in prison of between 0.4% (Sweden), 1.4% (Austria) and 5% (Spain). The rates of condom use for the last intercourse were between 0% (Belgium) and 30% for Spain (Rotily and Weilandt, 1999). In the Austrian contribution to that Network study (Spirig et al., 1999) it was found that 2.8% of the men stated that they were raped in prison, 1.4% stated that they had sexual intercourse with another man in prison, no one stated they had accepted payment for sexual inter-

course, and no one stated they had used a condom. The nature of the prison's physical environment (i.e., individual cells, shared cells, shared living units, dormitories, and barracks) can have particular impact on levels of coerced sexual activity, sexual abuse, and rape. Prison policy that allows children and young people to be housed with adults can also increase the vulnerability of young prisoners to sexual abuse. Staffing levels and levels of supervision of prisoner living areas can also have an impact on levels of sexual activity, both consensual and coerced. Although most sexual contacts in prisons are same-sex activities, heterosexual contacts may also take place. These may occur between prisoners and prison staff (which may be coercive in nature, particularly for female prisoners) or during prison visits (whether or not such visits are officially "conjugal" in intent).

3.2.3 Tattooing and body piercing

Tattooing amongst prisoners is a common practice in many countries. Research has revealed high levels of tattooing among prisoners in countries including Australia (Dolan and Wodak, 1999), Canada (Correctional Service Canada, 1996), Ireland (Long, 2003), Spain and the United States (Dolan, 1999).

Because tattooing involves breaking the skin with a needle, it is an activity that poses a risk of transmission of blood-borne diseases through the sharing and reuse of tattooing equipment such as needles and inks – both of which come into contact with large amounts of blood during the tattooing process. Tattooing and the possession of tattooing equipment are prohibited by prison authorities in many countries, and those found to be engaging in tattooing are subject to punitive sanctions. As a result, tattooing is an activity that takes place secretly, often in unhygienic environments, using homemade equipment and inks, and as quickly as possible so as to minimize the risk of detection by prison staff. All of these factors increase the risk of negative health consequences via tattooing in penal institutions (Bammann and Stöver, 2006).

Conclusive clinical evidence of HCV or HIV transmission via tattooing is elusive. One of the barriers to demonstrating a clear causal relationship between the transmission of blood-borne diseases and tattooing, particularly among prison populations, is the very high level of injecting drug use history among this group. It therefore becomes difficult to identify conclusively whether the source of infection was tattooing or syringe sharing. However, despite a lack of definitive evidence, there is significant anecdotal evidence of blood borne disease transmission through tattooing (inside and outside

prisons), as well as a body of scientific opinion identifying the potential health risk when tattooing occurs in a non-sterile environment. Several studies of prison populations have found evidence linking tattooing to the transmission of blood-borne diseases in prisons (Estebanez Estebanez et al., 1990; Holsen et al., 1993; Post et al., 2001; Samuel et al., 2001; Thompson et al., 1996).

On the related issue of body piercing, a review of various studies on the relationship between piercing and hepatitis transmission concluded that eight out of twelve studies identified percutaneous exposure, including body piercing and ear piercing, as a risk factor for viral hepatitis. Six of the studies found that hepatitis sero-positivity was significantly associated with ear piercing (Hayes and Harkness, 2001).

There are still other risks for transmitting infections in prison; Exposure to human blood and body fluids (if infected with HIV/HCV) has the potential for transmitting infections. Within prisons, both prisoners and prison staff may be exposed to human blood or other body fluids as a result of

- assaults and fights (which can lead to open wounds and bleeding)
- accidental needle stick injuries from hidden or concealed syringes
- carrying out professional duties (as is the case with medical staff)
- providing first aid.

3.2.4 Drug use and prevalence of BBVs in prisons

In Europe the HIV and HCV prevalence among prisoners is primarily related to the sharing of injecting equipment inside and outside of prisons. Sharing syringes among intravenous drug users is a high-risk activity for the transmission of HIV due to the residual presence of blood in the syringe after injecting (Shah et al., 1996; Shapshak et al., 2000). Given the secure environment of penal institutions, it is often more difficult to smuggle syringes into prisons than it is to smuggle in drugs (Lines 2002b; Lines 2002a). As a result, syringes are typically scarce, and prisoners who inject drugs share and reuse syringes out of necessity (WHO et al., 2004). For people who inject drugs, imprisonment therefore increases the risk of contracting blood-borne infections such as HIV, through sharing needles.

In a prison, a syringe may circulate among (often large) numbers of people who inject drugs, or be hidden in a commonly accessible location where prisoners can use it as necessary. A needle may be owned by one prisoner and rented to others for a fee, or it may be used exclusively by one prisoner,

reused again and again over a period of months until it disintegrates, is rendered totally unusable or is confiscated by prison staff (Lines 2002b; Lines 2002a). Sometimes the equipment used to inject drugs is homemade, with syringe substitutes fashioned out of available everyday materials, often resulting in additional vein damage, scarring, and injecting-site and other infections.

Injecting drug users (IDUs) in prisons are a far from homogeneous population, but one that comprises various subgroups that can benefit from targeted interventions:

- those who inject on the outside but not in prison;
- those with no previous history of injecting (approximately 5–10% of all IDUs start injecting while in prison);
- those who smoked drugs like heroin in the community but inject in prison, mostly for reasons of economy and efficiency;
- those who have a history of injecting in prison but no longer do so, having identified and resisted high-risk behaviour (similar to the first group);
- occasional injectors, for whom the behaviour may be opportunistic, recreational or impulsive;
- independent injectors, who are disciplined about risk reduction and have their own injecting equipment that they will not share or lend;
- closed-circle injectors, who share equipment only within their own group, whether to reduce risk or to avoid detection by prison officers;
- renters, who rent injecting equipment from others for money, drugs or favours; and
- hirers, who own injecting equipment and rent it out for a fee or service (Shewan et al., 2005).

There are obvious risk differences among these groups, especially for infection through contaminated equipment; for example, the renters are clearly at higher risk than the independent injectors. Moreover, all these groups will also contain both HIV-positive and HIV negative people, whose needs will often be different. HIV prevention programmes need to adjust their messages accordingly.

The high rates of injecting drug use, if coupled with lack of access to prevention measures, can result in frighteningly rapid spread of HIV. There were early indications that HIV could be transmitted extensively in prisons. In Thailand, the first epidemic outbreak of HIV in the country probably began among injecting drug users in the Bangkok prison system in 1988. Six studies

in Thailand found that a history of imprisonment was associated significantly with HIV infection. HIV outbreaks in prison have been documented in a number of countries, including in Australia, Lithuania, the Russian Federation and Scotland (Stöver et al., 2007).

Studies conducted in various countries illustrate the degree to which drug use occurs in prison. A national study in the US of 25,000 people who inject drugs found that approximately 80% had been in prison at some time (Dolan & Wodak 1999). A 1995 WHO study of HIV risk behaviour among people who inject drugs in 12 cities found that 60% to 90% of respondents had been in prison since commencing injecting drug use, with the majority experiencing incarceration on multiple occasions (Ball et al., 1995).

This is not to say, however, that prison has no effect on patterns of drug injecting. In fact, research has demonstrated that incarceration affects patterns of injecting and decisions about injecting in various ways, often with the result of increasing the risk of transmission of HIV and other blood-borne diseases. For example, while people who inject drugs typically inject less frequently in prisons (Shewan et al., 1996), studies have found that injecting tends to take place in a more “high-risk” fashion than injecting outside of prisons (Darke et al., 1998; Malliori et al., 1998). Drug users often choose to inject in prison when they would not normally inject outside prison, and networks of drug users who share injecting equipment can be larger in prisons than outside prisons (Long 2003; see for overview: Lines et al. 2006: 10). As stated by UNAIDS: “Long experience has shown that drugs, needles and syringes will find their way through the thickest and most secure of prison walls” (UNAIDS, 1997: 6).

Research has revealed a number of factors that encourage drug injecting among prisoners, or the switch to injecting among non-injectors. The inconsistent or scarce supply of drugs such as heroin is one. Because injecting is a more efficient means of drug consumption, resulting in less waste, it has been shown that some heroin smokers will choose to inject heroin rather than smoke it while incarcerated. The prison economy may also prove a factor, and provide an incentive for prisoners who “own” a syringe to rent it or trade it to others in exchange for drugs (Long, 2003).

In addition to the extensive evidence of high risk behaviours among prisoners in many countries, there is also documented evidence of the transmission of HIV, as well as blood-borne infections such as HCV, within prisons (see with more details Stöver and Lines 2006).

And there are still other drug-related problems occurring in prisons, which are not the topic of this report, such as

- overdose
- drug related death after release
- suicide
- self-harm
- tuberculosis.

3.2.5 *Transition from custodial settings into the community*

The health threats prison health care services are facing also affect public health, because drug using inmates are often serving short term sentences and then return to society, to their partners, their children and their families and may transmit blood borne infections into the wider community (WHO et al., 2001).

For many prisoners, the first two weeks following release from prison is particularly dangerous, as many prisoners resume (higher levels of) drug use and are at very high risk of drug overdose. In the week following release, prisoners are about 40 times more likely to die than the general population. In the period immediately post-release most of these deaths (over 90%) were associated with drug-related causes (Singleton et al., 2003). Prisoners who have not taken drugs frequently during detention often have difficulties in adapting to the new situation after release. They return to old habits and consume drugs in the same quantity and quality as before prison. The transition from life inside prison to the situation in the community is an extremely sensitive period. The longer a drug user stays in prison, the more difficult adapting to life outside prison will be. Even a prison sentence of only several weeks, during which no drugs are consumed, poses a considerable risk to released drug users: because of a reduced tolerance for opiates, even small quantities can be life-threatening (Stöver and Weilandt, 2007).

The additional problems faced by prison administrations throughout the EU in addressing health concerns of prisoners include the higher incidences of drug related deaths in prisons and shortly after release, suicide attempts, self harm and mental health problems (Bird and Hutchinson, 2006; Bird et al., 2003).

3.2.6 *Consequences of drug use for the prison system*

Prison management is faced with increased public pressure to keep prisons drug-free. This affects all forms of detention for men and women: punitive detention, pre-trial detention, detention of juveniles. Only a small number of prison managers talk frankly about the issue in public, establish adequate drug services and develop new drug strategies. Frequently, however, confessing that drug use also appears in prison is to be mistaken for failing to maintain security in prisons: the prison system which is supposed to be impenetrable for drug trafficking has turned out to be penetrable. The number of prison managers who deny or ignore drug use in prison for political reasons is still great. Additionally, many prison doctors believe that they cure the inmates' drug problem, when an inmate is temporarily obliged to stop using drugs. Against this background, it becomes obvious why dealing with addicts in detention is difficult: on the one hand the goal to achieve the inmates' rehabilitation must be pursued; on the other hand prison management in many countries faces rising drug consumption among inmates and with political and economic restrictions that make it even more difficult to solve the drug problem.

In prison the drug use patterns change. On the one hand drug use can become more risky in terms of injecting and needle sharing, on the other hand the frequency and prevalence of drug use decrease during imprisonment. A survey from England reveals that the rates of drug use in prison were significantly lower than in the previous year (Ramsay 2003a); 45% of the female prisoners had used a drug while in prison, compared with 72% in the year before prison. Once in prison there is also a tendency to use depressants rather than stimulants. In the survey of Ramsay (2003) 27% had used heroin and 21% had used cannabis. Similar results are presented by the Home Office (Home Office Research Development and Statistics Directorate, 2003). The main drugs which women reported using in prison were heroin (27%), followed by cannabis (21%) and tranquillisers (17%). However, 30% of the women said they were no longer using drugs at all in prison. These findings are supported by a European study on 185 female drug users in prison (Zurhold and Haasen, 2005). While all women used drugs prior to their imprisonment this number declines gradually to 60% and to down to 30 to 50% the longer the time they spend in prison.

In most countries, a differentiated system of sanctions and incentives has been developed in prisons in order to punish drug-using behaviour or to

reward those who remain abstinent within a unit or a treatment programme. Sanctions can include:

- additional days of imprisonment for positive urine tests
- forfeitures of privileges
- stoppage of earnings
- no home leaves
- no visits.

Incentives are designed to encourage good behaviour of prisoners and may include:

- transfer to a drug-free wing
- single cell
- home leave
- holiday
- in-cell television.

Evaluations of such programmes have also yielded some promising results with respect to high-risk behaviour among drug-dependent prisoners (WHO et al. 2004).

3.3 Prevention, treatment, and education programmes for prisoners

This chapter does focus on programmes and interventions of prevention, treatment, and education of drug using prisoners.² Existing interventions are described, and evidence for their effectiveness is displayed based on a comprehensive literature review. Usually the overall aims of treatment is to reduce re-offending, re-incarceration, and/or a reduction of substance use.

The EU Action Plan (2000-04) specified that the member states should intensify “their efforts to provide drug-prevention and treatment services and, where appropriate, measures to reduce health-related damages in prisons and on release from prison” (EMCDDA, 2003). The EMCDDA announced main areas for policy consideration on drug treatment in prison: need for research and monitoring, need for a better awareness of good practice, involvement of prison staff, effective interventions to reduce the risk of HIV and other infec-

2 Although there are some studies on psychosocial interventions for alcohol dependence, they are not included here. For an overview see Roberts et al.: Roberts, A.J., Hayes, A.J., Carlisle, J., Shaw, J. (2007). Review of Drug and Alcohol Treatments in Prison and Community Settings. A systematic review conducted on the behalf of the Prison Health Research Network. Prison Health Research Network, Department of Health, England.

tious diseases, equivalence of care, continuation of care on release (EMCDDA, 2003).

Heaps et al. (2009) emphasize the need for an integrated system of care, where service delivery is coordinated throughout the treatment process according to the needs of the client. No matter at what stage in the criminal justice system the client's coordinated care seems to be vital (Heaps et al., 2009). An example of good practice in organizing prison health care is a British document; In Great Britain a document on the "clinical management of drug dependence in the adult prison setting" was published in 2006. It aims at developing clinical services in prison and serves as a treatment model for all healthcare professionals in prison. It emphasizes e.g. the correlation between drug withdrawal and self-destructive behaviour, the importance of extended detoxification and maintenance treatment, a more systematic approach to clinical management, continuity of care and case management (Department of Health, 2006).

The number of drug treatment programmes in European prisons has increased within the last 15 years. This is associated with increasing numbers of drug using inmates and a response to infectious diseases in prison (Kolind et al., 2009).

Non treatment of drug using prisoners fails to address the causes of the imprisonment and therefore increases the probability of a circle of endless reincarceration (Seal et al., 2004: 787). Concerning recidivism between 70% and 98% of those imprisoned for drug-related offences and having no drug treatment experience a relapse occurs within 12 months after release (Kastelic and Kostnapfel Rihtar, 2007: 22).

Tensions exist in prison generally between help and control, punishment and treatment (e.g. Jacob and Stöver, 1998) and should be considered in treatment planning and organizing. This tension was increased e.g. in Denmark by a new drug action plan with increased pressure on drug using inmates. Although treatment is voluntary inmates may enter treatment because they fear disciplinary sanctions. Those not participating in treatment do face harsher terms of imprisonment like fines, solitary confinements and restrictions on weekend leave in case of a positive drug test. The new treatment programmes in Danish prisons (on cannabis user and those in OST) is according to the treatment counsellors subordinated to the prison institution (Kolind et al., 2009).

As most research on treatment in prison is looking at men, the applicability to women is not clear. At the same time incarcerated women differ from women in clinical samples in the community as well, so it is questionable, if those programmes would work for incarcerated women (Lewis, 2006). Female prisoners often have a different history than men in issues like drug use, family and social background, violence, mental and physical health. Therefore tailored treatment programmes might be necessary for their different needs, as usually prison-based drug treatment programmes are designed for male prisoners. Women have higher rates of sexual abuse as a child, which often is associated with low self-esteem and depression. As the treatment focus often is on the harmful effects of drugs on the individual and the family, this approach could do harm to women with abuse experience. In a study sample the women reported more often pain relief (both emotional and physical) as motivation for drug use, while men more often stated hedonistic reasons for drug use (Langan and Pelissier, 2001). Comparing men and women in a prison-based substance use treatment reveals a higher recognition of having a substance use problem and lower levels of self-efficacy to remain abstinent among women compared to men. Furthermore both men and women reported equally problem-solving coping strategies, but women were more likely to report using coping strategies of seeking social support, accepting responsibility, and escaping (Pelissier and Jones, 2006). Lewis gives some issues to consider for treatment of incarcerated women: The first step would be to acknowledge the gender differences. Besides the custodial staff should be aware of these differences and be prepared that working with women is different and might be more difficult than working with men. Awareness of victimizing situations and behaviour in prison is needed as well as adequate reactions on that. Moreover it is important to recognize the co-morbidity, therefore to provide an interpersonal therapeutic focus on relationships of the individual, case management, and therapeutic communities (Lewis, 2006). Another review suggests an enhancement model when treating female offenders, which should focus on the special needs of women and enhance their capabilities in living a balanced life. These needs include apart from drug use issues of physical and sexual abuse, mental health, children and families, vocation, and life skills (Sorbello et al., 2002). Furthermore, female gender is associated with higher cost for health care in the correctional setting in the US (de Groot 2000, cited in Lewis, 2006: 782).

3.3.1 Testing of and counselling on infectious diseases

Testing of infectious diseases is the prerequisite to organize the appropriate care and therefore ensure the prisoners' health as well as the health of their families and communities. As prison inmates are a high-risk group for acquiring infectious diseases, adequate prevention and care is needed. Early identification of the HIV status can reduce health care costs, AIDS-related mortality and morbidity, and can prevent transmission when risk behaviour is changed (De Groot et al., 2006). HIV testing can be performed voluntary or mandatory on admission to the prison. The testing rate of voluntary testing can be increased by counselling, private informed consent and brief group counselling (Liddicoat et al., 2006), and by offering oral tests instead of blood tests (Bauserman et al., 2003). On the other hand, mandatory testing as well as segregating infected inmates are known to be counterproductive (Jacobs, 1995; WHO et al., 2007d).

Voluntary counselling and testing of HIV on prison entry is high, but unsystematic on release (Hedrich and Carpentier, 2009). Access to HIV testing is limited in many correctional settings (De Groot et al., 2006). Of the 52 WHO Europe countries (response rate 42.2%) HIV screening is done in 31.8% (seven countries), four countries (18.2%) report mandatory testing (Aerts et al., 2006). Testing for hepatitis is done to varying degrees, on admission, on request, or in high risk groups only.

Tuberculosis (TB) is concentrated on high-risk groups and prison inmates belong to these risk groups, as TB is over-represented among inmates in many countries, especially in Eastern Europe. A survey among the 52 WHO Europe countries revealed a high TB active screening at prison entry in 90.9% of the responding countries (in 50% compulsory), in 63.6% also during the time of imprisonment. These numbers might be biased as the response rate of countries answering was 42.2%, with Western European countries over-represented. The majority of the countries houses TB patients separately (Aerts et al., 2006). In the Netherlands the coverage of TB screening at prison entry increased between 1994 and 2007 while the positive TB cases remained the same with a prevalence of 84 per 100,000 screenings. TB can be attributed to the following risk groups: undocumented persons, drug addicts, homeless persons, asylum seekers and immigrants living less than 2.5 years in the Netherlands (Haddad and Erkens, 2009).

An US study among female prisoners showed that testing for sexually transmitted diseases (STD) is feasible and accepted by many of the women pris-

oners approached. A sample of 5364 tested female inmates in three US cities revealed high prevalences of chlamydial (15.3% – 21.5%, depending on the city) and gonococcal infections (8.2% – 9.2%) especially among those aged under 25 years (Mertz et al., 2002). Therefore blood-borne viruses and sexually transmitted diseases also might need close monitoring, as they are over-represented in prison settings.

Testing of HIV and other infectious diseases should always be confidential and be accompanied by adequate counselling, especially when the test result is positive (MacDonald, 2006). Testing should be easily accessible for prisoners on entry and during imprisonment, and always be accompanied by pre- and post-test counselling, be embedded in care and treatment for those tested positive (WHO et al., 2007d). Prisoners might refrain from HIV testing and/or treatment for fear of discrimination (MacDonald, 2006: 216), as HIV positive inmates might be stigmatized or fear to be, and don't always trust the medical confidentiality (De Groot et al., 2006). This issue should be addressed in treatment planning and counselling as well as in general information and education approaches for all inmates.

3.3.2 *Hepatitis A+B vaccination*

As prison inmates are a high risk group for hepatitis, the vaccination especially for hepatitis B (HBV) is an important public health issue. The vaccination is so effective that any approach to injecting drug users needs to build the provision of such vaccination as a key outcome of contact with injecting drug users (Farrell et al., 2010). In 13 of the EU member states Hepatitis B immunization campaigns in prison are implemented (Hedrich and Carpentier, 2009). In a Scottish survey of the mid-1990ies only 4% of inmates have been offered HBV vaccination (Bird et al., 1997). Two HBV vaccination campaigns were launched in England in 2001, and subsequently implemented in all English prisons. Self-reported vaccine uptake rose between 1998 and 2004 from 27% to 59% in the country (Gilbert et al., 2004a) and the achievement was highly attributed by prisons (Hope et al., 2007). HBV vaccination should be available for all prisoners (Sutton et al., 2006).

Vaccination for hepatitis A is not offered regularly in most prison systems, but should be offered to high risk groups (Neff, 2003). After an increase of HAV in the community of South Yorkshire, a HAV vaccination programme was expanded to the prison, which had a significant impact on the HAV incidence in the community (Gilbert et al., 2004b). Only once a HAV outbreak in

prison was recorded, it occurred in Queensland, Australia (Whiteman et al., 1998).

An English project offers a full range of vaccines (HBV and HAV, as well as others like diphtheria, tetanus, measles, rubella) to inmates and could improve the coverage of all vaccines, although to different degrees (Modi et al., 2009).

Vaccination especially of HBV should be offered to inmates on a regular basis – and if necessary of other infections as well – from the Public Health point of view. Vaccination campaigns need to be accompanied by information and counselling.

3.3.3 Treatment for infectious diseases

Antiretroviral treatment (ART) and highly active antiretroviral treatment (HAART) are effective treatment options in suppressing the HIV virus load, which has been shown in numerous studies. It can also be realized in prison without any problems, but still prison authorities are sometimes reluctant to fully implement it, not least because of the financial costs.

Adherence to treatment was higher in prison than outside in a Spanish study (Soto Blanco et al., 2005). Prisoners should be encouraged to participate in this treatment in prison, also when they haven't been in treatment before (Stöver et al., 2008). As for the modality of treatment the literature is inconsistent. In directly observed therapy the patient swallows the medicine under supervision at the medical department, which ensures regular drug intake. On the other hand, this may lead to a fear of "stigmatization" by the prisoner in front of other prisoners or staff as he frequently attends the medical unit (Babudieri and et al., 2000; Pontali, 2005).

Interruption of antiviral treatment (AVR) treatment is a major public health threat as the risk of creating multi-drug resistant strains of the virus rises (Hassim, 2006). Therefore HIV treatment is important to continue after release, to organize this and cooperate with community services is necessary (De Groot et al., 2006).

Effective HCV treatment consists of a combination of pegylated interferon and ribavirin. Depending on the genotype of the virus the duration and success of treatment vary (Fried et al., 2002). A sustained virological respond (SVR) was found in 47.5% of treated inmates in French prisons (Remy et al., 2006), in a Canadian study SVR was achieved by 66.3% (Farley and al.,

2005; Farley et al., 2005). The results show, that treatment for HCV is feasible and safe in prison setting and is able to reduce the prevalence of hepatitis C.

Treatment for TB patients follows WHO recommendations in 90.9% of WHO Europe countries, but e.g. Spain and Slovakia reported drug shortages (Aerts et al., 2006). Treatment of TB becomes more and more difficult, as multi-drug resistant TB develops and increases in many prisons.

Antiretroviral treatment for HIV as well as treatment for HCV and TB should be available to all prisoners who are in need of it. Infected prisoners are entitled to adequate health care in the light of the principle of equivalence of care (see chapter 3.6).

3.3.4 Information, education and communication on drug use and infectious diseases for prisoners and prison staff

Information and education programmes on HIV and other infectious diseases are important measures to prevent further transmission. It includes usually information on transmission, transmission routes and preventive strategies.

The following objectives should be met (according to: Stöver and Trautmann, 2001; Stöver et al., 2008):

- To raise awareness of health problems connected to drug use and infectious diseases, transmission routes (injecting, tattooing, piercing), sexually transmitted diseases
- To initiate and support a discussion about risk reduction
- To increase knowledge and skills of both prisoners and staff on drug use and infectious diseases, transmission routes (injecting, tattooing, piercing), and sexually transmitted diseases
- To encourage a positive attitude toward risk reduction activities by both prisoners and staff
- To disseminate accurate information in a non-judging way in all relevant languages
- To stimulate and support the realisation of risk reduction activities for both prisoners and staff
- To consistently ensure the availability of information, e.g. seminars on safer drug use and safer sex
- To meet the needs and personal resources, including interactive learning possibilities

- To use different modalities: peer-support/education, posters and other materials, awareness campaigns, information by health care services, outside services.

Knowledge on HIV issues is greater among those offenders who frequently attend different education formats, thus calling for the need of multi format ongoing education programmes for offenders on HIV (Belenko et al., 2005). Another important area is that of peer-led programmes, which can be very effective. A HIV peer programme lead to increased knowledge on HIV in a Siberian prison (Dolan et al., 2004). Peer education also was successful in a youth programme on drug use, the peers were motivated and the juveniles picked up more from their peers than from staff (Lodewijks, 2006). A rather unusual approach to promote harm reduction measures and information on infectious diseases is the Jailbreak Health Project in Sydney, Australia. This radio show is broadcasted weekly for half an hour and aims to provide support and health information. Peer-led health promotion messages are broadcasted as well as personal stories from prisoners and ex-prisoners about risk-taking behaviours and experiences (Minc et al., 2007).

It is vital to integrate prisoner's experiences and expertise in the development, designing and delivery of information material to increase their appropriateness and scope (Kastelic and Kostnapfel Rihtar, 2007). For staff training the following issues are important to include in order to improve the work with drug using inmates: confidence in skills, personal rewards, job satisfaction (Airey and Marriott, 2003). The implementation of information and education generally should be in a non-judging fashion. An integrated approach between prison and community health services is more successful.

3.3.5 Drug testing

Drug testing can serve a variety of aims like deterring drug use in prison, identify drug users and provide help services, or estimate the level and type of drug use (MacDonald and Harvey, 1997). Testing in prison is usually done by urinalysis, and – depending on the aims – is performed in different modalities and frequencies; on admission and/or release, before/after holiday, per random routine, by suspicion (Dean, 2005). Drug testing tends to be a control measure rather than a form of treatment, especially when a positive drug test leads to negative sanctions within the prison. The assumption of controlling drug use by the measure of drug testing is widespread. Drug testing can only be considered as a part of treatment when it is used in a therapeutic way.

Thus it can be implemented into a drug-free treatment with consent of the inmate and without negative sanctions. Drug testing does not replace drug treatment but can only be an instrument in treatment setting (Borkenstein, 1983). Benefits of drug testing in a therapeutical setting may be to reduce temptations and to facilitate treatment (Borrill et al., 2003: 61).

Mandatory drug testing (MDT) on the other hand can not be considered as a form of treatment or service at all. In 1995 MDT was introduced in England and Wales, first only in eight prisons, in early 1996 it was expanded to all prisons in England, Wales and Scotland, despite lacking evidence of effectiveness (Gore and Bird, 1996). Instead of evidence base it reflected political rhetoric of the early 1990ies (Hughes, 2000a). Each month 10% of the inmates were tested (MacDonald and Harvey, 1997). Refusing to provide a urine sample could be disciplined, and for positive tests additional days were added to the sentence, up to 14 days for a positive test of cannabis and up to 21 days for a positive test on class A drugs (Hughes, 2000a). Despite the initial idea to provide treatment for those tested positive, studies showed that this was not the case (Edgar and O'Donnell, 1998; Hughes, 2000a). In 2005 the Scottish Prison Service announced after 10 years of MDT the discontinuation of this programme, while already in 2002 the measure of serving additional days for a positive test result was discontinued (Dean, 2005). A cost analysis of MDT in England and Wales revealed costs twice as high as running a drugs reduction and rehabilitation programme in prison, the major cost-generating factors being punishments for positive test results, refusals to be tested and positive tests for cannabis (Gore and Bird, 1996). Another concern during the MDT programme was a significant rise in the number of assaults in the first year after introduction of the programme (Gore et al., 1996), as MDT increases tensions in prison, and besides it needs and binds staff resources (MacDonald and Harvey, 1997). Changing from cannabis to heroin is done to avoid detection by MDT, as heroin is only detectable a few hours/days while cannabis can be detected for weeks. In a sample of female prisoners in England 3% reported changing from cannabis to heroin in prison (Borrill et al., 2003: 60), which poses a serious public health risk. Another study found that just over the half of drug using inmates desisted, reduced or altered their drug use because of MDT, but only few changed from cannabis to heroin (4% of drug using inmates started with heroin in prison), and if they did, this was not permanently. Another 6% reported to have reduced their cannabis use but continued heroin use (Edgar and O'Donnell, 1998). Both inmates and staff have reservations against MDT. Substantial parts of prisoners

(57%) and staff (40%) believed that MDT would lead to a change from cannabis to heroin use (Edgar and O'Donnell, 1998). 40% of the staff believed MDT to be disproportionate, therefore they did not always perform tests even if they suspected drug use (Edgar and O'Donnell, 1998). In qualitative research inmates thought MDT to be unfair and embarrassing (Hughes, 2000a).

Other countries implemented MDT as well. In Canada random drug testing is done since 1995 among a minimum of 5% of the federal inmate population, in order to reduce substance use in prison. But an analysis between 1994 and 1998 showed significant increases of positive test results overall and especially for cannabis, so the aim to reduce substance use of this rather expensive measure was not met (Kendall and Pearce, 2000). In Denmark MDT was introduced in 2004, with each prisoner being tested approximately every 40th day. Sanctions for positive tests include fines, solitary confinement and suspension of weekend leave (Kolind et al., 2009).

Even if MDT is done regularly, it is likely to underestimate the prisons drug use, as a Scottish study shows, where only one to two thirds of injecting drug use were detected by MDT. This therefore underestimates the number of drug users in need of drug treatment (Bird et al., 1997). The underestimation might be due to a rather high level of detection threshold in order to minimize false positive results (Edgar and O'Donnell, 1998), and was shown again in 2010 (Chambers, 2010).

The effectiveness of MDT in tackling prison drug use is scarce, on the contrary it encourages people to evade detection, discourage seeking help for fear of detection and punishment and does not support individuals drug use management (Hughes, 2000a), furthermore it increases tension among inmates and staff, and underestimates the prevalence of prison drug use (Chambers, 2010). To sum up, mandatory drug testing is counterproductive in many ways (see WHO et al., 2007d) and should not be used.

Therefore drug testing should only be used as part of a wider treatment approach, e.g. in drug-free units, and with the consent of the inmates, in order to help them keep control over their drug use behaviour.

3.3.6 Prison based drug demand reduction programmes

Drug demand reduction programmes include a number of different treatment approaches and usually can be described as drug-free and abstinence-oriented aiming at support prisoners in leading a drug-free life (The Patel Report and Prison Drug Treatment Strategy Review Group, 2010). The most common

approaches include Therapeutic Communities (TC), drug-free wings and cognitive-behavioural treatment. Often these programmes are run in separate sections of the prison to ensure a more therapeutic attitude and a high control standard. Often drug testing is part of the programme. Drug demand reduction programmes in prison are provided in most European countries, but to different degrees and often not in all areas of a country (Turnbull and Webster, 1998).

The strongest evidence for effectiveness according to an English research was firstly behavioural skills training, and second cognitive-behavioural therapies and motivational interviewing (Harrison et al., 2003). An US meta-analysis on the effectiveness of prison-based treatment for drug dependence found therapeutic communities effective in reducing reoffending, in contrast to boot camps and drug-focused group counselling. For other interventions not enough evaluation studies were found to draw strong conclusions. Altogether the quality of research was poor, which supports typically a bias in favour of the experimental programme (Pearson and Lipton, 1999). Comparing TC with drug treatment programmes and comparison groups in prison settings found TC effective in reducing re-arrest and re-incarceration but not concerning drug relapse. The latter was only achieved in combination with mandatory aftercare. Furthermore (full-time) employment reduces relapse and recidivism (Welsh, 2007). Prison-based therapeutic communities were studied in two RCTs and were significantly effective in reducing re-incarceration 12 months after release compared to no treatment in one trial. The second trial showed significant fewer re-incarcerations, criminal activity and alcohol and drug offences within 12 months after release compared to a mental health treatment programme (Smith et al., 2007).

In the Netherlands addiction support units, formerly called drug-free units, are established in prisons. The average stay is four months, and they have a special focus on throughcare and sustainability of care. This is achieved by employing external drug services in these units, the staff is employed at the external services which provide care in the community, so a continuity is achieved. Participation in these units is voluntarily although sometimes policy tries to put pressure on the drug users to participate (van den Broek, 2000). In a drug-free programme in one prison in Hamburg/Germany the criminal recidivism was followed up and evaluated. The programme was conducted in two wards, separated from the rest of the prison, with a professional therapist in each ward and daily drug tests for the inmates. Participants were followed on average for 6.2 years after release between 1990 and 1998;

those participants who finished the programme regularly had a significant lower recidivism rate than drop-outs and a non-treated control group. A drop out during the first 100 days was related with a worse outcome of nearly 100% crime recidivism rate after 5 years. The drug free wing was successful in preparing for a consecutive therapy treatment but did not necessarily succeed on the long run. A control group of those who applied for the drug free wing but were rejected did not show worse outcomes on recidivism than those who completed the wing and better outcomes than early drop-outs (Heinemann et al., 2002).

Some groups of inmates need specific forms of treatment. Treatment should be gender-specific and tailored to the different needs of men and women. Evaluation of cognitive-behavioural treatment approaches from 20 different prisons in the US found no differences in outcome among the 16 programmes for men with overall positive results (despite differences in specific policies, programme emphases, and staff experience), while of the four programmes for women one had significantly higher rates of drug use and another one had significantly lower rates of recidivism. There appeared to be greater variation in the implementation of the four programmes for women (Pelissier et al., 2005). Another group are stimulant type drug users, for whom a lack of tailored treatment options in prison was stated in a European research (Decorte, 2007).

Abstinence-oriented programmes can be a good opportunity for those prisoners who are motivated to cease their drug use, although altogether not many studies have been conducted on the effectiveness of psychosocial interventions in the prisons setting (Strang et al., 2007). The existing evidence points towards lower criminal activity, recidivism and relapse. As the programmes of drug-free units vary greatly, the exact factors in contributing to the positive effects are not known, furthermore the impact on criminal recidivism remains limited and conflicting (see Jürgens et al., 2009).

3.3.7 Throughcare

The time before and after release from prison is vital concerning future criminal activity, drug use and re-incarceration (Inciardi, 1996; Porporino et al., 2002; WHO et al., 2007b).

One of the major risks upon release is that of overdose deaths. For example 15% of overdose deaths in England in 2005 occurred shortly after prison release (EMCDDA, 2009). Between 1999 and 2001 prisoners in an English

study were 40 times more likely to die than the general population, the greatest risk was in the first week after release, and normalisation occurred after the fourth week after release (55 deaths per thousand per annum). The majority of post-release deaths were drug-related deaths (Singleton et al., 2003). As the majority of post-release drug users did already experience or witness non-fatal drug-related overdoses, Wakeman et al. call for a post-release naloxone programme to prevent overdose deaths. Peer-administered naloxone as antidote to heroin overdose was successfully implemented in a number of community trials (Wakeman et al., 2009).

As prisoners have several needs on release concerning accommodation as well as employment, health issues and psychological needs a multi-modal aftercare is needed (Crow, 2006). A high degree of continuity of impairment was reported by released prisoners in an Australian study. This included pre-released physical or mental health problems, high levels of psychological distress, and history of injecting drug use or risky alcohol use. These impairments had significantly higher risk to increase after release. This underlines the importance of pre-and post-release planning and delivery of interventions (Kinner, 2006). An Austrian survey among recently released prisoners revealed that the accomplishment of the actual situation was of much greater importance than any future plans. Social contacts were rated more important than during imprisonment, and the need for accommodation and employment is far higher after release, also the need for professional support is rated to be higher after release (Krucsay, 2007).

Most countries were lacking drug demand reduction treatment in all stages of the criminal justices system (CRS) (Turnbull and Webster, 1998). Access to drug treatment is often disrupted in police detention, and health care availability in police detention varies between countries but generally the principle of equivalence is not met (MacDonald, 2004). Although an increase in the prevalence of drug use in police custody is observed, treatment interventions are either not available or only available with disruption (Payne-James et al., 2005). In Illinois an individual case management programme called TASC provides care for drug using offenders throughout the criminal justice system. It is cooperating with all parts of the criminal justice system and treatment agencies according to the needs of the individual client (Heaps et al., 2009).

According to Turnbull et al. two key factors increase the success of treatment regarding re-offending and drug use: the duration of treatment (the longer the better) and support on release (Turnbull and McSweeney, 2000). In Austria a

project on release preparation was evaluated. The programme “Schritt für Schritt” starts around four months before release and includes case management with a focus on job training by external social workers. Intensive contact before release predicted a participation after release. At the end of the programme the individual aims were achieved in almost one third of cases, in another third partly. Participants stressed the importance of such case management programmes on release. A good cooperation between the prison and the external social workers is vital (Hammerschick and Krucsay, 2007).

A US study found that increased time spent in prison-based drug treatment also increased the participation in aftercare and furthermore decreased the rate of 12-months recidivism (Burdon et al., 2004). A five-year post-release follow up study showed lower re-incarceration rates for those inmates who participated in prison-based treatment and even lower with higher employment rates in those who also attended aftercare (Prendergast et al., 2004). Another American study found offenders who attended community aftercare after prison-based treatment have less drug use and better economically situation than those who do not (O’Connolly 2007, cited in Leukefeld et al., 2009), and prison-based treatment can enhance offenders chances of a successful transition (Leukefeld et al., 2009). For parolees to stay drug-free is more likely when they participate in an aftercare programme in the community. To be successful, programmes need to cooperate with criminal and social service agencies and follow principles of effective treatment (Prendergast, 2009).

Guidelines were developed in an US project on improving re-entry of drug using offenders to ensure successful work on re-entry. Major issues in these guidelines are; increasing communication across agencies, more consistency of drug treatment inside and outside prison, re-entry process should be tailored to the needs of the offender and begin at least 6 months before release, preparation before release is crucial, community support systems of different kind should be identified and used, and case management should target issues like housing, employment and family support (Leukefeld et al., 2009). In the Russian republic of Khakassia a throughcare project on TB was implemented, where health coordinators and psychologists from the Red Cross visit TB infected prisoners one month before release and organize further treatment in the community with them, including social help. The percentage of former prison inmates who attend TB treatment in the community increased from 62% to 98% (Garder et al., 2009).

To sum up, especially vital on prison-based treatment outcome is a good aftercare covering the vulnerable time of the first few months after release (Zurhold et al., 2005: 244). As the concepts of aftercare are often unclear in the criminal justice system, it is difficult to answer which type of aftercare is best suited for which client. Additionally there might be a bias when comparing those in aftercare and those not. The authors conclude that research is needed on the effectiveness of different types of aftercare before assumptions can be made about the effectiveness (Pelissier et al., 2007).

3.3.8 *Conclusion*

The criminal justice system presents opportunities and challenges when addressing a wide range of clinical and social care needs of drug users. The experiences of getting drug users in prison to engage in treatment can have a positive impact. However, treatment in prison and the wider criminal justice system is not always based on evidence. For example the majority of programmes for drug using offenders in the US employ less than 60% of specified evidence-based practices (Friedmann et al., 2007). The success of treatment may vary due to different aspects. Higher motivation for treatment is associated with greater cognitive engagement in treatment, higher retention in treatment and better progress. The effectiveness of prison-based treatment depends on the inmate's level of internal motivation for treatment (Rosen et al., 2004). Drug treatment in prison focuses more often on opiate and/or cannabis users. Accordingly a lack of tailored treatment options for alcohol and also stimulant drug users in European prison was stated (Decorte, 2007). An example for rather unsuccessful treatment options is naltrexone as treatment for heroin using inmates. An Australian study found low acceptance among inmates of naltrexone, and significantly lower treatment retention rates than in methadone treatment (Shearer et al., 2007).

Research on treatment in prison generally is difficult and for different fields a lack of research can be stated.

Finally, integrated care pathways, from the community into prisons and visa versa, and a balanced treatment system are vital to ensure that individuals get access to the types of treatment that is appropriate to their changing needs and circumstances. "Local commissioners need to be able to choose from a broad spectrum of treatment options in both prisons and the community including prescribing and residential rehabilitation" (The Patel Report and Prison Drug Treatment Strategy Review Group, 2010: 9).

3.4 Harm reduction

Behind harm reduction lies the philosophy that if a person does not cease the drug use, nonetheless the harms associated with drug use should be minimized. Harm reduction measures aim at reducing the risks and harms connected with drug use and especially injecting drug use. In the community harm reduction was introduced in many countries after HIV and AIDS became an issue and (injecting) drug users being one of the main risk groups for HIV infection and transmission. However, implementation of harm reduction measures in prison was much slower and still is patchy throughout different countries. Harm reduction measures in prison are often perceived as threatening and inappropriate, undermining security in prison and contrary to the abstinence paradigm.

A wider range of harm reduction measures is often implemented after outbreaks of infectious diseases or high prevalence in the prison setting. In Scotland for example, several harm reduction measures were implemented in a prison after an outbreak of HIV seroconversions in this prison. These measures included the availability of HBV vaccination, HIV counselling and testing, the provision of bleach tablets, a methadone detoxification programme, access to harm minimization counselling and increased training for prison officers. 12 months after implementation no further HIV cases were detected, but the transmission of hepatitis C is likely (Goldberg et al., 1998). Similarly Indonesia implemented different measures to combat HIV and AIDS in prison due to high HIV prevalence. These measures include the provision of condoms, bleach, OST, and antiretroviral treatment as well as educational sessions for prisoners and staff training (Winarso et al., 2006).

Similar to injecting equipment the needles used for tattooing can transmit infectious diseases. Tattooing is often as illegal in the prison setting, but some countries provide sterile tattooing equipment in prison. Training to reduce tattooing-related transmission is reported on (Lenton, 2003), and a peer-education programme on tattooing was evaluated in a Russian prison, which seems to reduce the prevalence of tattooing (Dolan et al., 2004). In six Canadian prisons tattooing pilot projects were set up in 2004 with tattooing parlours run by inmates (Jürgens, 2004).

Despite the existence and policy support of several harm reduction measures, a survey among incarcerated women in Canada revealed that the availability of measures such as education and methods of reducing HIV/HCV transmis-

sion is variable. While testing was available to large extends, pre- and post-counselling was perceived as problematic (Rehman et al., 2004).

3.4.1 Needle exchange programmes

Needle and syringe exchange programmes aim at a reduction of needle sharing and therefore the transmission of HIV and other infections. The first prison-based needle and syringe exchange programme (PNEP) was implemented in 1992 in Switzerland; in 2000 a total of 19 programmes were in place (Dolan et al., 2003), and in 2006 70 programmes existed in 9 countries with more expected to start in a number of countries (WHO et al., 2007a), while in Germany six programmes were closed down again for political reasons and despite good experiences and outcome (Stöver, 2003). On the other hand in Spain all prisons were ordered to provide sterile syringes to substance using inmates in 2001 (Nelles and Stöver, 2002).

PNEP has been implemented in a number of different prisons settings; men's and women's institutions, small and large prisons, prisons with individual cells and group accommodation, in prisons with different security levels, remand and sentenced, open and closed forms of prison (Stöver and Nelles, 2003). Different models of implementation have been evaluated: syringe supply by vending machines, hand-to-hand distribution by medical staff, by drug counsellors or by external staff as well as trained peers (Jürgens et al., 2009; Lines et al., 2005a). Advantage of the first is a better possibility of anonymity, on the downside machines are prone to break down. The hand-to-hand distribution, especially by outreach workers, can improve contact and facilitate counselling, on the other hand, availability might not be given for long hours (Lines et al., 2005a) and anonymity is not guaranteed. Distribution by peers can improve the acceptance of the programme and the issue of trust and anonymity. In Romania the distribution of syringes and information material is done by peers only, after a first initiation by the medical staff. The peer educators are indirectly supervised by the medical staff and receive the material each day to pass on to drug users (Ionescu, 2009).

In a German trial of needle exchange in a Hamburg closed prison the daily passing on/sharing of used syringes decreased from 41% to 0%. Furthermore no new incidences of HCV were found during the project, while in the time before the project this was at 14.7% during an unclear time period (Glet, 2008). In one open prison in Hamburg the evaluation of a syringe exchange programme in 1996–1997 revealed that before the implementation of syringe exchange machines virtually all injecting drug users in prison shared needle

or syringe with others at least sometimes. The syringe machine was used by 90% of those injecting in prison, and 17% reported to still share the syringe with others sometimes (Gonsior, 2000). Due to numerous break downs of the syringe vending machines the supply with syringes was insufficient, so the frequency of needle sharing was reduced but not diminished. Furthermore inmates reported to be tempted by the overall availability of syringes (Heinemann and Gross, 2001). Technical problems with the vending machines also occurred in the women's prison in Berlin, still the inmates preferred this mode of syringe exchange (Stark et al., 2001). An evaluation in Berlin/Germany found a massive decrease of needle sharing from 71% before the start of the project to 11% after four months and almost zero afterwards. Of n=174 four cases of HCV seroconversion occurred but none for HIV and HBV (Stark et al., 2006). A demand for sterile injecting equipment was clearly drawn from high numbers of exchanged syringes in two Berlin prisons. Varying demand can be explained by varying availability of drugs and varying numbers of drug-using inmates (Stark et al., 2001). The number of abscesses and fatal overdoses decreased according to research in some prisons (Lines et al., 2005a).

Despite numerous evidence of the effectiveness needle and syringe exchange programmes are often still met with "irrational hostility" (Michel et al., 2008) and rejection. Political and moral resistance to prison based needle exchange programmes both by staff and politicians is often high. The evaluation of a German PNEP found relevant prejudices and fears among the security staff of the prison. The low acceptance was mainly based on the fear of dangerous situations because of increased number of syringes and also because of unclear situations what to do in the case of finding a syringe. Two thirds of the staff regarded the project as neither useful nor sensible, and felt highly insecure about the project. This resulted in not homogenous behaviour during syringe findings. Hostility against the project was also found among prisoners who don't use drugs or want to keep away from the drug using milieu. No additional drug use was observed during the project (Glet, 2008). In an open prison with vending machines acceptance of staff was low, although no threats in connection with syringes were recorded during the project. This calls for the need of early integration of staff into the planning, and taking seriously their fears (Heinemann and Gross, 2001). Other evaluations found generally high acceptance among staff and prisoners when the programme was running (Jürgens et al., 2009).

Evaluation studies have all been in favour of needle and syringe exchange programmes. Effects that could be observed, although not necessarily due to the programme, include (according to Dolan et al., 2003):

- No new cases of HIV or hepatitis were reported
- The rate of drug use decreased or remained stable in most evaluations
- Good integration into the health system
- Increase in referrals to drug treatment
- The rate of overdose decreased.

As Rutter et al. (2001) put it, “the rationale for establishing syringe exchange programs in prison is even stronger than in the community” as a rapid turnover of the prison population and high infection rates makes incarceration to a strong predictor of HIV and HCV (Rutter et al., 2001: 1). Easy and confidential access for prisoners to the needle exchange programme is vital for the success of the programme, otherwise prisoners are reluctant to use the programme and rather go on with hiding and sharing syringes (Jürgens et al., 2009).

Concluding it can be said, that in none of the projects evaluated new incidences of HIV occurred, the needle sharing was strongly reduced, although not completely in all places. No increase of drug use was observed, in some cases even a decrease and also injecting behaviour did not increase. In addition the following was observed; overdose incidents and deaths were reduced, greater prisoner contact with drug treatment facilities, reduction in abscesses, increased awareness of infection transmission and risk behaviour, improved relationship between staff and prisoners, increased staff safety due to the decreased risk of needle injuries during cell searches (for comprehensive overviews and reviews see Jürgens et al., 2009; Lines et al., 2006; WHO et al., 2007a).

3.4.2 Opioid Substitution Treatment (OST)

Opioid Substitution Treatment (OST) aims at both harm reduction and social reintegration. Medication used in OST can include methadone, buprenorphine, codeine, morphine, and diamorphine, the most common is methadone, in some countries buprenorphine. Often in prisons these medications are used for detoxification purposes on the short-term (which is not considered as OST, see Larney and Dolan, 2009), while long-term maintenance treatment is not as readily available. The provision of OST often differs not only between countries but among single prisons in one country (Michel and Maguet, 2003;

Michels et al., 2007). Although OST continuation on imprisonment is approved officially in 26 countries of the European Union, in most countries OST is not provided in all prisons. The initiation of OST in prison is approved in 21 countries (EMCDDA, 2009). But prison-based OST is now available in more EU countries than five years ago (Hedrich and Carpentier, 2009). For example, in 1996 prison-based OST was implemented in five countries only worldwide, in 2008 there were at least 29 countries or territories (Larney and Dolan, 2009). Treatment with diamorphine (heroin) in prison has only been tried in Switzerland and was feasible (Kaufmann et al., 2001). There is a need for more diversification in medication and in providing the same medications as outside (Metz et al., 2010). Even in those countries where OST in prison is available, the proportion of substitution patients in prison is often lower than in the community, with great variations between the prisons according to the type of prison, the size, the location and the medical unit (e.g. Michel and Maguet, 2005). The highest proportion of inmates in OST are found in Ireland and Scotland with 14% of all inmates and Spain with 12%, while in other countries OST is provided to less than 1% of inmates, and in some countries OST exists as a pilot project with few patients in single institutions, therefore treatment coverage seems not enough for achieving HIV prevention on population-level (Larney and Dolan, 2009). In a French study 77.7% of N=507 opioid dependent inmates in 47 remand prisons were enrolled in OST, which indicates an enormous increase compared to older studies (Marzo et al., 2009). Similarly in Austria the number of opioid-maintained prisoners increased by 444% between 1996 and 2007 (Metz et al., 2010). Another limitation is that of restrictions to treatment access; in a number of countries the access to treatment is limited to inmates who have been in treatment before or can confirm a treatment after release, or who serve a sentence of specific length (Larney and Dolan, 2009). There are at least 37 countries that offer OST in the community but not in prison (Larney and Dolan, 2009), which is not according to international human rights and prison guidelines and recommendations. English prisoners perceive OST in prison as inconsistent and diverse in prescription practice, e.g. another type and dose as they had outside (Hughes, 2000b). Although seen as valuable addition to OST psychosocial care in connection with OST was rarely provided in the European countries (Stöver et al., 2006).

Already the first evaluation study on prison-based OST in 1969 found promising results concerning re-addiction and re-incarceration at 7–10 months post-release, when methadone treatment was started ten days prior to release

(Dole et al., 1969). Prison-based maintenance treatment can reduce the frequency of injecting (Dolan et al., 2002; Lenton, 2003), heroin use, sharing syringes (Dolan et al., 2002), and involvement in the prison drug trade (Dolan et al., 1998). A RCT on the long-term effects of prison-based OST showed that retention in OST is associated with reduced mortality, reduced HCV infection and reduced mortality. The risk of re-incarceration was lowest with at least eight months of OST, while a short duration of two months or less in OST had the highest risk of re-incarceration (Dolan and et al., 2003). A reduction in (officially recorded) crime rates for different kind of offences (e.g. robbery, break and enters, motor vehicle theft) was observed in an Australian study (Lind et al., 2004). OST also has a positive impact on post-release drug use as well as referral rates into drug treatment and antiretroviral treatment after release (WHO et al., 2007b). Mostly methadone is used in prison-based OST, but a French study showed that buprenorphine has similar effects on the re-incarceration rate (Levasseur et al., 2002). In a French study, OST was not associated with reduced re-incarceration rate nor reduced mortality at three-year follow-up. Patients in OST were preferably those with poor social integration, heavy opioid use and prison history, hence with a higher risk of recidivism (Marzo et al., 2009: 1238). In an RCT conducted in the US, three groups were compared: counselling only, counselling with transfer to OST after release, and thirdly counselling plus OST in prison. The third group showed a significantly greater treatment entry after release, which on the other hand is associated with reduced rates of drug use and re-incarceration. Furthermore the rate of opioid use at one month after release was significantly lower in the second and third group compared to the first group (Kinlock et al., 2007). Also at three month post-release these results were confirmed. The third group had significantly less re-incarceration rates and was more likely to attend drug treatment (Kinlock et al., 2008). The positive results were also confirmed at six-months after release (Gordon et al., 2008). An Australian RCT found significantly lower heroin use at four months follow-up than in a waitlist control group. Those in prison-based OST reported less drug injection and syringe sharing at follow-up (Dolan and et al., 2003). As prison-based OST can reduce re-offending and re-incarceration it may help to decrease expenditures of the Criminal Justice System (Metz et al., 2010).

A delay in starting OST in prison seems to increase the chance of high risk injecting practices in prison (Michel et al., 2008), therefore it should be started immediately after incarceration. Continuity of treatment is needed

between prison and community (Stöver et al., 2006). Disruption of substitution treatment leads to an increased risk of injecting drug use, sharing of equipment as well as psychological and physical problems (Stöver et al., 2004).

A recent systematic review identified five studies on the effectiveness of OST in prison on injecting-related HIV risk behaviour. Of the five studies two are from Australia, and one each from Canada, Iran, and Puerto Rico. Compared to non-treated inmates the illicit opioid use decreased significantly by 62 – 91%. Two of the studies found significantly decreased injecting drug use by 55% and 75% respectively, one did not find a difference here. Self-reported needle and syringe sharing was significantly reduced by 47% – 73%. No data was available on the HIV incidence under OST. The review emphasizes the need for research on the effects of prison-based OST on HIV risk behaviours and incidence. Although the evidence suggests an impact of OST, methodologically rigorous studies are lacking (Larney, 2010). A sufficient dosage of the substitution medication seems to be important for the retention rate (Stallwitz and Stöver, 2007; WHO et al., 2007b), an increasing dosage seems to reduce concomitant drug use during treatment compared to a stable or decreasing dosage (Johansons, 2000: 31). On the other hand, overdosage can be fatal, therefore prison doctors need to be careful when prescribing methadone. As prisoners are often not tolerant to opioids anymore or not on the same level, prescribing in prison should start with low dose (Kinlock et al., 2007). This also applies when prisoners get treatment immediately after imprisonment and get the same dose as in the community but did not take it all by themselves anymore, while in prison they have to. These seem to be single cases (Daniels, 1997). A further aspect of OST was emphasized already in 1993 in a New York jail, that inmates who received methadone were less irritable and easier to manage than other inmates from the view of corrections staff (Magura et al., 1993).

Looking at financial issues, OST might be cost-effective, as a Canadian study concludes that in the long term the CJS might spend less money on inmates in OST as these offenders remain in the community for a longer time without re-incarceration (Correctional Service of Canada, 2001).

Despite reluctant implementation in many prisons and countries prison-based OST is effective in many ways (see WHO et al., 2007b), stabilizing both health and social factors (Stallwitz and Stöver, 2007). Prison-based substitution treatment is effective in reducing mortality, crime rates, re-incarceration

rates, and HCV infection. It reduces drug use both inside prison and after release. Adverse effects of prison-based OST like security issues, violent behaviour, methadone diversion was not found (Jürgens et al., 2009). Hence prison-based OST should be provided in all countries where it is provided in the community (Dolan and et al., 2003). Treatment duration should last the entire period of imprisonment and the dose should be sufficient (Stallwitz and Stöver, 2007).

3.4.3 Provision of bleach and disinfectants

The provision of bleach or other disinfectants for sterilising injecting equipment is available in a wide range of countries with no reported safety or security problems. If available bleach is used by a large proportion of prisoners, but it is questionable how effective it is used. To be effective in sterilizing the equipment, the process duration is rather long and complicated, thus prisoners often don't follow recommended guidelines for disinfecting. There is no sufficient evidence that the provision of bleach is effective in decontaminating injecting equipment (Jürgens et al., 2009). As no evidence for the effectiveness of bleach in the community exists, it is rather unlikely to be effective in prison settings. The situation in prison with the fear of being detected and not exactly knowing how to disinfect effectively raises doubts on the effectiveness and furthermore may lead to a false feeling of security. Additionally bleach might be effective on the HI-Virus but not 100% on the hepatitis C virus (see e.g. Kerr et al., 2004; WHO et al., 2007a).

Few studies exist on the provision of bleach for disinfecting injection equipment. A Scottish one found providing bleach suboptimal (Champion et al., 2004), therefore it should only be second-line strategy (for a comprehensive review see WHO et al., 2007a; WHO Europe, 2005).

3.4.4 Provision of condoms, dental dams, and water-based lubricants

The provision of condoms aims at preventing sexually transmitted diseases (STD), condoms being the most effective method for risk-reducing of sexual transmission of HIV and other STDs (WHO and UNAIDS, 2001). Water-based lubricants reduce the risk of condom breakage, while dental dams reduce the risk of STD transmission during oral sexual contact (WHO et al., 2007c).

Most countries do provide condoms for the inmates, but the mode of provision varies greatly; sometimes prisoners have to buy them in the prison shop,

sometimes they are available at the medical unit, or prisoners have to ask for it, in some countries and prisons condoms are available anonymously in different places of the prison, in others they are only available for long-term visits or for holidays and on release, in others condoms are totally prohibited. In some countries the access is limited or only possible in a few prisons (MacDonald, 2004). Data on the availability of water-based lubricants or dental dams is patchy only.

No negative consequences have been reported from those prison systems where condoms are available and the provision seems feasible in a wide range of prison settings (Jürgens, 2006). No increase in sexual activity was found as well as no security and safety problems were reported, on the other hand decreased risk behaviour and high use of condoms occur after the initiation of condom provision (WHO et al., 2007c). To be accepted and therefore used by inmates the access to condoms needs to be easy, anonymous and discreet, possibly in varying locations (e.g. toilets, day rooms, workshops), as prisoners might fear detection (WHO et al., 2007c). French studies showed, that one third of prisoners believed condoms not available in prison although they were, and almost the same amount had to ask the doctor or medical staff for it (Michel et al., 2008). Alongside with free, confidential and easy accessible condom provision information on STD for both prisoners and staff is required, as knowledge on transmitting HIV and other STDs often is poor (WHO et al., 2007c).

3.4.5 Training and engaging prison staff in implementing harm reduction services

Harm reduction measures are often perceived as threatening and the introduction is hindered or complicated by resistance from staff. The prison is usually perceived as a drug free environment by both prisoners and staff, therefore harm reduction measures seem to oppose this goal (see Stöver et al., 2004). Issues like infectious diseases also concern the safe working place of prison staff, therefore regular training and information on infectious diseases, their prevention, treatment and needs of those infected is indicated. This enables staff to protect themselves against infections.

Prison officer's perceptions on the risk of HIV transmission by infected inmates is related to their knowledge about HIV and therefore influence the officer's behaviour towards the inmate (Alarid and Marquart, 2009). The fear of infectious diseases leads to workplace stress for prison officers, and the perceived risk of infection was higher among those officers with lower

knowledge on HIV and lower levels of education (Alarid and Marquart, 2009). Swiss prisons report a great interest and need in staff training and information about issues related to infectious diseases, especially in the big institutions (Masia et al., 2007). Not only harm reduction issues are important to focus on in staff trainings. Prison doctors report high needs of training in an English survey. Almost three fifths of surveyed doctors cared for mentally ill inmates without training in general psychiatry. Also the doctors felt that the generic training in the community wasn't sufficient for practicing in prison, and especially for those with less experience training is needed according to the doctors' opinion. The needs cover clinical conditions, especially psychiatric training, as well as topics related to the impact of custody on health care (Gray et al., 2006).

An important issue is that of patients' confidentiality. Staff training should emphasize that it is not necessary or important to know the infection status of individual prisoners (MacDonald, 2006: 208). Other important issues are stigmatization and discrimination, as well as confidentiality of medical information.

In Germany a training programme for both staff and inmates was implemented on harm reduction issues in the 1990ies. The programme aimed at sensitizing the staff for hidden risks, identification with the objectives of infections prophylaxis, medical basic knowledge, respect and satisfy security needs. Important was the orientation on resources instead on deficits. Morally and patronizing methods decreased the efficiency of the message. Issues were similar for staff and drug users and include risks with mode of application, injecting, drug sharing, disinfection, transmission of infectious diseases (Heudtlass and Stöver, 1998). Three goals should be met: identification with the goal of preventing infectious diseases, acquiring basic medical knowledge, and accepting and meeting individual and collective needs for safety. Furthermore seminars on harm reduction issues for staff need to be accompanied by structural changes in order to be effective, and to be repeated (Stöver and Trautmann, 2001).

Drug treatment and harm reduction measures can only be successful when staff is informed and supportive about it. Staff training can change the attitude towards more acceptance of harm reduction measures. It can enable them to more self-esteem in dealing with the prisoners.

3.4.6 Conclusion

Despite numerous studies on the effectiveness and feasibility of harm reduction measures in prison, the availability and provision is incomplete and patchy in many countries. Resistance against these measures is high, mostly concerning PNEP. This means, that incarcerated drug users often would not get the help they need (UKDPC, 2008). Thus successful health promotion and prevention programmes need to balance correctional regulations, public health issues, societal stigmas and taboos and normative beliefs of incarcerated inmates (Seal et al., 2004: 787). The two approaches abstinence based treatment and harm reduction measures don't need to be contradicting each other necessarily. Looking at the availability of drug services for imprisoned women throughout Europe, a preference to favour abstinence treatment models rather than harm reduction measures can be observed (Zurhold and Haasen, 2005), and this is also true for men's prisons. "What approach is adopted in prison rarely has anything to do with evidence-based practice" but rather with the suitability with the prison ethos (Turnbull and McSweeney, 2000). One example for this is the provision of bleach, which is not supported by evidence in reducing transmission of HCV, but as PNEP is often not provided, bleach is seen as a more convenient (for the prison staff and administration) alternative. An example of even anti-evidence is mandatory drug testing, where more negative than positive outcomes were measured and the goals were largely not achieved. "Risk reduction programmes must address both individual (e.g. substance abuse) and structural factors (e.g. substance abuse treatment)" (Seal et al., 2004: 788), and prisoners can play a vital role in order to improve treatment quality and provision (Stöver et al., 2006). Barriers in implementing harm reduction needs to be tackled and worked on, in order to ensure the best possible care for prisoners. Consented efforts are needed to implement harm reduction measures in prison as they have important public health impacts.

3.5 Involvement and support of NGOs

Regular contact with local community services and the involvement of voluntary agencies can assist greatly in promoting health and well-being in prisons. Where possible, prisoners should be connected to key community services before leaving prison, such as probation or parole and social and health services (see Møller et al., 2007).

Counselling and the involvement of community health structures including NGOs is a key part of connecting prison health care with public health care. Disease prevention material from the outside cannot simply be transferred to the prison setting – the relevant target groups require prison-adapted versions. This requires input from different groups based on interviews and focus-group discussions. Initial drafts and designs need to be tested and approved. Both prison staff and prisoners greatly influence any prison environment. Both groups should therefore participate actively in developing and applying effective preventive measures and in disseminating relevant information.

Involvement and support from municipal health structures should have priority; non-governmental hepatitis, HIV/AIDS organizations have especially valuable expertise and networks that can contribute to enhance the quality of material development and sustain this as an ongoing activity.

Some Länder in Germany include external drug service providers in taking care of inmate drug users. Some prisons even have their own advisory bureau on drug issues, and the social workers in some prisons take care of these problems. In contrast to internal workers, prisoners more widely accept and trust external workers because the outsiders have a duty to maintain confidentiality and have the right to refuse to give evidence. Moreover, the external workers are more experienced and know about the content of and requirements for the various support services offered. Counsellors on drug issues in prison should primarily provide information about the various support services and programmes available inside and outside prisons. In a second step, their efforts should focus on motivating prisoners to overcome their drug use. A major advantage of external drug counselling is that it links life inside and outside the prison and thus is very helpful for continuing treatment that was started in prison.

3.6 International Guidelines on prison health, human rights etc.

The UN have published a number of recommendations on prisoners health since the 1980ies including the principle of equivalence of health care in 1990 and the ban of medical staff involved in any form of torture, inhuman or degrading treatment and punishment (Elger, 2008: 194).

UN recommendations and as well as Council of Europe recommendations are referred to as “soft law” as they are not legally binding, other than conventions which are signed by states and therefore binding. The latter include the

European Convention on Human Rights and the European Convention for the Prevention of Torture, both signed by all 97 Council of Europe members (Elger, 2008).

The European Convention for the prevention of torture views insufficient health care as violation of article 3 of the European Convention on Human Rights (Elger, 2008: 195). The Council of Europe recommendation from 1998 said that the role of the Ministry of health should be strengthened in the area of prison health (Council of Europe, Committee of Ministers. Recommendation No R(98)7).

WHO guidelines on HIV infection and AIDS in prison include voluntary testing, confidentiality, non-discrimination of HIV-positive inmates, availability of prevention means, and access to treatment equivalent to that in the community (Bollini et al., 2002).

According to a research among four European countries were the 1993 WHO guidelines on HIV infection and AIDS in prison (WHO, 1993) only fully implemented in one out of four studied countries (Switzerland), partly in Italy and Hungary and not in Russia. At this the national policies mirrored the policies from the community – with delay. Reasons for the only partial implementation of the WHO guidelines were specific national regulation or prison rules that did not allow full implementation. Also, some aspects might not be relevant in some countries, e.g. when there are hardly any drug users like in Hungary at the time of the survey (Bollini et al., 2002).

The WHO in the Moscow declaration “Prison health as part of public health” calls for equal responsibility for health in prison by prison health and public health, and emphasizes the connection between public health and prison health. As prisons contain overrepresented marginalized populations with poor health and untreated conditions, both health systems are responsible. Urgent measures are needed to be carried out in the majority of European countries (WHO Europe, 2003).

The Council recommendation 2003 on harm reduction and the EU drugs strategy 2005–2008 objective 13: “further develop alternatives to prison and drug services in prison”. and 2009–2012: “provide access to health care for drug users in prison to prevent and reduce health-related harms associated with drug abuse” (Hedrich and Carpentier, 2009).

“However, harm reduction interventions in prisons within the European Union are still not in accordance with the principle of equiva-

lence adopted by UN General Assembly, UNAIDS/ WHO and UNODC, which calls for equivalence between health services and care (including harm reduction) inside prison and those available to society outside prison. Therefore, it is important for the countries to adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve access to services. The continuity of these services, including quality and access, should be ensured after release from prison.” (Commission of the European Communities, 2007).

Ethic principles on prison healthcare can be found in various conventions, declarations and recommendations. These principles include (see Pont, 2006):

- The primary task of the prison doctor is health and well-being of the inmates
- Free access to a doctor
- Equivalence of care
- Patient’s consent and confidentiality
- Preventive health care
- Humanitarian assistance (for most vulnerable prisoners: pregnant, juvenile, ethnic minorities, etc.)
- Professional independence (difficult with dual locality, when under prison administration, civil servant)
- Professional competence

The compliance with these principles results in professional advantages like: promoting the confidence of inmates, leaving no doubts on medical professionalism, preventing misunderstandings, providing guidance in conflicts, supporting quality assurance, protecting against legal appeals, and giving international support (Pont, 2006: 263). Free access also means sufficient medical staffing and enough time and resources to look after all prisoners. Consent and confidentiality also includes true, informed consent, where the patient understands the consequences of the decision (Pont, 2006: 264). Preventive health care includes suicide prevention, prevention and treatment of transmitting diseases like TB, hepatitis and HIV, screening, and counselling (Pont, 2006: 265). Despite the international rules and recommendations prison doctors still need to reflect continuously their personal ethical obligations (Pont, 2006: 266).

The “Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia” was prepared by international experts and released in Dublin during the conference “Breaking the barriers: Partnership in the fight against HIV/AIDS

in Europe and Central Asia” in 2004. This declaration contains a statement of eight fundamental principles which are followed by a framework for action. These principles include (Lines et al., 2005b):

- People in prison are part of our communities
- People in prison have a right to health
- Good prison health is good public health
- Protecting the health of prisoners, and reducing the transmission of disease in prisons, also protects the health of prison staff
- Sex and injecting drug use occur in prison, and are in many prisons widespread
- Harm reduction must be the pragmatic policy basis for fighting HIV/AIDS in prisons
- States must act collectively to fight against HIV/AIDS epidemic
- Action to fight hepatitis C in prisons is as crucial as is action to fight HIV/AIDS

Another policy declaration is the “Lisbon Agenda for Prisons”, which was presented and discussed at an international symposium in Lisbon in 2003. This Agenda was adopted by different groups such as the European AIDS Treatment Group (EATG) and signed by international experts, it contains measures to reduce the prevalence and incidence of drug problems through demand reduction (diversified treatment approaches, alternatives to imprisonment), measures to reduce drug-related morbidity and mortality (prevention of blood borne infectious diseases), measures to improve the perspectives for life after release (rehabilitation, drug and infection services), measure to overcome barriers to implementation (overcoming negative attitudes, overcoming fear of inmates to be disclosed, overcoming safety concerns), measures to optimise policy implementation (Uchtenhagen, 2006).

Recently experts adopted the “Madrid Recommendation: health protection in prisons as an essential part of public health” at a meeting in Madrid 2009 with representatives from 65 countries worldwide. This recognizes the urgent need for measures in prison such as: treatment, programmes for infectious diseases, and for drug users, harm reduction measures, guidelines on hygiene requirements, guaranteed throughcare for prisoners, mental health support for prisoners suffering from communicable diseases, training of all prison staff on prevention, treatment and control of communicable diseases.

A framework to address HIV/AIDS in prison was published by the UNODC and authored by Lines and Stöver. This framework includes eleven principles

and a 100-point action plan in order to assist governments to meet international obligations on human rights, prison conditions and public health. The recommendations for action can be divided into ten areas: political leadership, legislative and policy reform, prison conditions, funding and resources, health standards and continuity of care, comprehensive and accessible HIV/AIDS services, staff training and support, evidence-based practice, international as well as national and regional collaboration, implementation at the national level (Lines and Stöver, 2006; UNODC and WHO, 2006).

4 Profiles and problems of health care delivery in the prisons and NGOs visited – trends and responses to drug use in prisons in the sample countries

4.1 Estonia

4.1.1 General information on the prison system

In Estonia seven prisons existed at the time of the survey:

- Harku: convicted females and juvenile females
- Murru: convicted adult male, camp-type prison
- Pärnu: adult males awaiting trial, convicted adult males
- Tallin: convicted adult males, adult males and females awaiting trial, camp-style prison built in the 1950ies.
- Tartu: founded in 2000, entered service in 2002, for max 924 inmates. Maximum security prison with cells for convicted males, and males and females held in custody
- Viljandi: convicted juvenile males (closed by now)
- Viru: opened 2008
- Ämari: convicted adult males (Quaker Council for European Affairs, 2007; Subata and Rotberga, 2009)

In addition a number of arrest houses exist throughout the country. These are for those detainees held for up to 30 days, but the duration can exceed even a period of three months (Stöver, 2008).

In 2007 5% of the expenditure of the “National drug addiction prevention programme” was spent for drug prevention in prison, of which the biggest amount (88%) was spent for armed forces and mobile devices to detect drugs, the rest went for drug testing (National Institute for Health Development and Estonian Drug Monitoring Centre/REITOX National Focal Point, 2008)

4.1.1.1 Prison statistical data

In Estonia there were 3,656 inmates at 01.01.2009 (Walmsley, 2009). Estonia has the highest imprisonment rate in the European Union, although numbers declined over the past years (see figure 1, adapted from Walmsley, 2008a)

with 273 per 100,000 inhabitants in the beginning of 2009 (Walmsley, 2009). The occupancy level (prisoners per 100 places) was 94.2 in the beginning of 2009 (Walmsley, 2009). 27.1% were pre-trial prisoners (Walmsley, 2009).

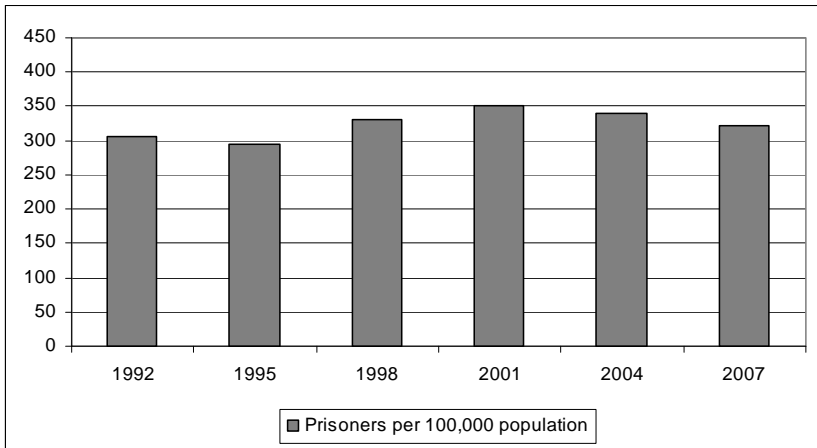


Fig. 1 Imprisonment rate Estonia

The number and percentage of female prisoners is rising since 2000; 3.6% in 2000 (Quaker Council for European Affairs, 2007), 4.8% in 2006 (Council of Europe, 2007), and in 2009 the percentage of females was already 5.2% of all prisoners (Walmsley, 2009). The mean age of prisoners was 31.5 years. 2.1% of inmates were under the age of 18 and 8.4% aged between 18 and less than 21 in 2006 (Council of Europe, 2007). 40.4% of prisoners were foreign, most of them Russians (Council of Europe, 2007).

The average prison sentence is four years according to a survey by the Quaker Council (Quaker Council for European Affairs, 2007) and re-incarceration is common (Arnadottir et al. 2002, cited in Stöver et al., 2008). Council of Europe data on the length of imprisonment in 2006 can be seen in table 4.

Table 4 Length of prison sentence in Estonia (%) in 2006

Less than one year	11.2
from one year to less than three years	24.9
from three to less than 10 years	51.5
more than ten years	11.3
life imprisonment	1.0

(Council of Europe, 2007)

The mortality rate in Estonian prisons lies at 20.4 per 10,000 inmates. The suicide rate is at 2.4 per 10,000 inmates. This is both below European average (Council of Europe, 2007). Drug-related deaths occur in prison. In 2005–2006 three IDU prisoners died of fentanyl poisoning (National Institute for Health Development and Estonian Drug Monitoring Centre/REITOX National Focal Point, 2008). Drug-related deaths have occurred in Tartu prisons (Stöver, 2008: 21).

10.9% of staff in the penal institutions is treatment staff, which is about the European average (Council of Europe, 2007).

The most common reason for drug users being incarcerated in Estonia are crimes against property (Stöver, 2008). In 2003 only 4.4% of sentenced prisoners were convicted for drug offences, while on the EU average this was 18.5% (Council of Europe, 2004). In 2006 it was already 9.6%, which stands for 314 cases (Council of Europe, 2007). For women prisoners most offences were drug-related, either property offences or directly drug-related (Quaker Council for European Affairs, 2007).

The majority of inmates in Estonian prisons are Russians (50% in 2006), followed by Estonians (44.6%) and only few other Nationalities (5.4%) (Lommus and Trummal 2006, cited in Stöver, 2008).

In 2007 the number of drug-related crimes increased by 50%, which is due to a change in law that drug distribution in prison is now registered as drug-related crime. In total 596 persons were brought to court because of drug-related crimes (National Institute for Health Development and Estonian Drug Monitoring Centre/REITOX National Focal Point, 2008).

4.1.1.2 Prevalences of HIV, HCV, HBV, TB, and drug consumption

Estonia has an expanding HIV/AIDS epidemic with 1.4% in the adult population in 2005. The incidence rate of HIV infection is by far the highest in Europe with 504.2 per 1.000.000 inhabitants in 2006 (Stöver, 2008). This epidemic is mainly due to injection drug use. In prison IDUs are overrepresented and high risk behaviour occurs widely.

The first case of HIV in a penal institution was registered in 2000 and in 2006 more than 600 prisoners were HIV-positive (Stöver, 2008). Of the inmates in Tartu prison (939 in 2009) 10% were infected with HIV (Subata and Rotberga, 2009). In Tallin prison approx. 20% of inmates have a HIV infection, of these 220 persons were 60 in ARV treatment (Stöver, 2008). Most inmates have been infected before coming into prison, according to official MoJ data seven cases have been infected in prison (Stöver, 2008).

In Tallin prison approx. 50% of the inmates are Hepatitis C infected (Stöver, 2008). There were 24 tuberculosis cases in 2005 in Estonian prisons, in 2008 there were 22 inmates with TB (Stöver, 2008).

A study among 598 inmates from three prisons (Murru, Harku, Viljandi) revealed that many prisoners did not know about their infectious status; 89% of those with Hepatitis B, 79% with hepatitis C and 22% with HIV infection did not know this, many of them were injecting drugs in prison (Faber, 2008).

Drug use in Estonia has increased considerably during the 1990ies. At the same time the drug policy got restrictive, often due to international impact. Both prevalence and perception of drug use changed in the course of post-soviet market reform as well as the drug treatment system (Lagerspetz and Moskalewicz, 2002).

Drug use in prison varies between the prisons. In a recent survey tablets were ever used by 14–17% of inmates, cannabis by 5–21%, and alcohol by 9–22%. Injecting drug use in prison was practiced by 2–14% (Faber, 2008).

Most drug using inmates are detained in Tartu prison since a drug-free unit opened there in 2007 (Subata and Rotberga, 2009). From 939 inmates in 2009 in Tartu prison 30% were drug dependent, further 8% drug users without dependency syndrome.

A survey among IDUs in two Estonian cities found 29% of them injecting in prison, and of those 69% reported sharing needles in prison (Uusküla et al 2005, cited in Stöver, 2008). Needle and injecting equipment sharing is very

common because there are not many syringes around in prison, which leads to high risk behaviour, using needles again and again and sharing among many people (Stöver, 2008).

The route of administration used by prisoners when taking drugs was for 70.8% smoking, 62.7% injecting, 45.4% tablets, and 28.4% inhaling (see Stöver, 2008). Needle and equipment sharing is practiced in prison more often than outside by 73% vs. 52% (Faber, 2008).

Females in prison are often addicted to harder drugs than men, i.e. outside prison women use methadone from the black market or heroin (Quaker Council for European Affairs, 2007).

4.1.1.3 National Policies and Practices on drug use in prisons

The responsibility for the penitentiary system in Estonia was transferred from the Ministry of Interior to the Ministry of Justice in 1993. In 2000 a new law – the Imprisonment Act – came into force. This was accompanied by a new structure of the Prison Department (Stöver, 2008).

The National HIV and AIDS Strategy for 2006–2015 states that “all necessary HIV prevention measures that are implemented outside prison should be available also in the prison” (cited in Stöver, 2008). This includes e.g. needle and syringe exchange and OST. The strategy schedules methadone maintenance treatment to be implemented in prison. The Action Plan 2006–2009 aims at 315 prisoners receiving OST (Subata and Rotberga, 2009), but this task was not achieved. The “concept of fighting against drugs in prisons” by the Ministry of Justice allows the initiation of OST in prison, although prison staff assumed not to be possible (Subata and Rotberga, 2009).

A “prisons’ drug prevention strategy 2002–2012” is part of the National drug prevention strategy (Quaker Council for European Affairs, 2007).

According to a research project it is not possible to replace imprisonment by drug addiction treatment (National Institute for Health Development and Estonian Drug Monitoring Centre/REITOX National Focal Point, 2008).

4.1.1.4 Drug Services

Prevention

According to the Ministry of Justice the majority of prison staff and prisoners underwent a training on HIV and other diseases between 2004–2005 (Stöver, 2008). Training and education campaigns both for staff and inmates has led to a less hostile attitude towards HIV-infected prisoners (Stöver, 2008).

The NGO Convictus offers discussion and information hours on HIV and related topics, with more than 2000 participants each year between 2004–2005 (Stöver, 2008). Convictus also published a number of leaflets, books, brochures, and calendars together with prisoners on HIV, infectious disease, drug use and similar topics. Nowadays Convictus has groups in every Estonian prison and also offers consultations with medical specialists, on medical issues and drug dependence (Tarvis, 2008).

Testing and Vaccination for Infectious Diseases

Testing for HIV and tuberculosis used to be compulsory in Estonian prisons until 2002 (Quaker Council for European Affairs, 2007). Now testing for HIV and Hepatitis C is possible for drug using inmates on a voluntary base. At prison entry and at least once a year inmates are offered to undergo the test for HIV. About one quarter does not undergo testing. Counselling and voluntary testing is provided to all prisoners (Stöver, 2008). Antiretroviral treatment is possible for those with HIV-infection. Not all inmates get it, there are resentments against it also within the inmates. Of 638 HIV-infected inmates 105 received HAART treatment in 2006 (Stöver, 2008).

Hepatitis B vaccination is available but due to financial problems not always put into practice. TB-screening is offered as well and recommended for all HIV-infected inmates (Stöver, 2008).

OST

Although it is possible by law to give methadone both for detoxification and maintenance therapy in prison, it is rarely implemented in prison settings. There are no legal obstacles to implement opioid substitution treatment, but practically it doesn't take place. In 2009 there was one prisoner in the Tallin prison receiving OST (Subata and Rotberga, 2009). According to the National report by the Reitox National Focal Point, neither detoxification nor

OST are available in prison (National Institute for Health Development and Estonian Drug Monitoring Centre/REITOX National Focal Point, 2008).

Main obstacles in implementing OST in Estonian prisons have been identified by Subata and Rotberga as follows: discontinuation of methadone treatment in arrest houses before coming into prison, negative attitude among psychiatrists, in the general society and also among inmates due to bad experiences outside prison (Subata and Rotberga, 2009).

Harm Reduction

Harm reduction measures are not sufficiently provided (Stöver, 2008). Condoms are available but often not in a discreet way. In Tallin prison condoms are available at the medical doctor by request and in conjugal visit rooms. Discussions occur, whether condoms are used for drug smuggling, therefore the practice/policy is somehow repulsive (Stöver, 2008).

Bleach is provided in Estonian prisons, but the effectiveness is very questionable. The correct use to disinfect injection equipment is complicated and needs time. So the availability of bleach leads to a “pseudo-safety” (Stöver, 2008: 58).

Other Treatment

Psychiatric services are available in the medical department of Tartu prison since 2005, being responsible for all Estonian prisons (Subata and Rotberga, 2009). A drug-free unit is available in Tartu prison since 2007 with 44 places (Subata and Rotberga, 2009). Harku prison has a drug-free unit since 2007 with 8 places and in Viru prison two units will be opened for males and for juveniles (Stöver, 2008). The NGO Convictus offers counselling for small groups or individuals in all Estonian prisons. Most treatment options and efforts in reducing drug use in prison are abstinence-oriented (Stöver, 2008).

Throughcare

There seem to be problems with discontinuation of treatment both from the community into prison and vice versa (Stöver, 2008). There are problems in continuing AVR treatment after release as many inmates don't show up in the community to continue the treatment (Stöver, 2008).

4.1.2 Results from field visits

Field visits included interviews with representatives of the (i) Ministry of Justice, (ii) governor, social worker, nurse and focus group (seven female prisoners in DFU) at Harku prison (female prison), and the (iii) Tallinn prison (male prison): nurse, focus group (nine male prisoners) and the head of social services. The field visit took place from 23–27 November 2008.

4.1.2.1 Ministry of Justice

In the Ministry of Justice the fact has been emphasized that in contrast to the nineties the hidden discrimination against people living with HIV/AIDS (PLWHA) (first medical staff then security then prisoners) has decreased. This is due to the fact that on the one hand the management of the HIV/AIDS disease including education and treatment for guards as well as for prisoners has been increased, and that on the other hand the number of patients with HIV has increased considerably. HIV infection seems to be no longer an issue of stigmatisation and/or discrimination.

HIV infection is seen as the major health problem, then drug addiction and dental problems. At the time of the visit there were 670 HIV-positive people in prisons, 100 of them received ART. That means that every fifth to sixth prisoner in Estonia is HIV-positive.

Tattooing is still part of the prison culture as a part of being in prison. Self harm and suicide is more or less frequent in the first stage of imprisonment, also due to drug use or detoxification. Self harm is more characteristic for remand than for convicted prisoners. Self harm is more spread among men than among women. For the men Tartu prison is the key prison to introduce OST. But very few prisoners received OST yet. There is no health insurance for prisoners.

Drug strategy

At the time of the visit the Estonian draft drug strategy for prisons was just ready to be released in 2009. It contains descriptions of principles of good practice and procedures and protocols: e.g. DFU, condoms, treatment.

Despite new prisons built drug use and drug trafficking remained a topic. In Estonia drug addicts are mainly being sent to Tartu prison, whereas drug dealers are transferred to Viru prison.

Complaints

Complaints are supervised by the Ministry of Social Affairs (MoSA, Department of Health Care), and given back to the Ministry of Justice (MoJ) in order to handle the response.

Services and structures for drug users

A variety of services and interventions is offered for drug using inmates.

DFU

In Estonian prisons drug free units have been developed. In Viru there are 20 places for adults and 20 for juveniles: 20. Tartu has a DFU with 44 places, and 174 in treatment altogether in different treatment programmes. In Harku eight places in the DFU are provided. Tallin has no DFUs – interested prisoners are being transferred to Tartu. In the Murru prison mainly alcohol dependent persons are treated.

The representative of the Ministry of Justice is stating that there is a refusal to introduce OST, because there seem to be no eligible patients, because drug users previously in OST have already been detoxified in arrest houses.

Condoms

Condoms are supposed to be distributed in the medical units for free. However, visits show that in Tallin prison condoms are not provided. They are distributed in shops and for conjugal visits (long-term visit rooms). Extra strong condoms are not available, nor lubricants. Convictus is no longer providing condoms, as part of an agreement. This means a substantial loss, as they provided a lot of condoms earlier. Condoms are seen as provoking sexual abuse, as the assumption is that sex is happening only in form of rape.

The university of Tartu released a study on sex in prisons, a summary on condom provision appeared in a newspaper article, 20th of March 2008 in the lead newspaper.³

3 Aime Jõgi. "Justiitsministeerium salastav vangi seksu uuringu". Postimees. 20.03.2008. Also available online: http://tartu.postimees.ee/190608/tartu_postimees/uudised/318730.php (English title: "Ministry of Justice made a secret/confidential research on prisoners' sex")

NGOs

NA is offering group work in Tallinn, not in Tartu, AA has been in Tallinn until recently (June 2008). Convictus are doing support groups in many prisons. There are no other NGOs in the prison field. Convictus training for staff is showing that the attitude towards drug addicted prisoners and PLWHA is important to change. Even management of NEP (outside) was of interest to staff.

HCV and HBV are tested for members of risk groups right at the beginning of imprisonment, no HCV or HBV treatment is available yet. Vaccination is provided for risks groups. The UNODC was considering a grant for arrest houses and Ministry of Interior in order to introduce OST. The idea of promoting harm reduction was stronger in 2003 and before. At that time MoJ even supported the idea of NEP, but this changed due to new staff working. The legal framework is still the same. Now the decision is taken to introduce OST in Tartu.

4.1.2.2 Harku prison⁴

Interview with the governor

At the time of the visit there were 120 sentenced female prisoners; 76 uniformed staff and 40 non-uniformed. The number of prisoners is decreasing in the last decades with the highest figure in 1991 with 170 lowest 50. 70% are Non-Estonians; 10–15% are convicted for murder. HIV is the main health problem, 50% of prisoners are HIV-positive. To them information and therapy are provided.

In all prisons 24 hours health service is provided, but not in Harku. Guards are providing some medications, including pain killers.

HIV testing is voluntary with very few refusals. Pre- and post test counselling is done. A repetition of the test is offered after 12 months, and for special risk occasions in between. Sometimes rumours around HAART and its side effects are stronger than medical advices.

The main strategy to combat drug consumption and trafficking in prisons are efforts to control the drugs smuggled into the prison. Although priority is given to monitor drug smuggling, at the moment there is no technical equip-

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ment, dogs can be brought from other prisons; there is social control of certain behaviour.

Regular urine tests is the main control instrument; in 2008 not a single positive urine has been detected. In 2007 there were 5 cases. Two prisoners experienced drug overdoses, they were reanimated by staff. Fentanyl (“White Chinese”, synthetic opium) is the most widespread drug, but not to be detected in the urine test.

Earlier in 2000 there was discrimination against HIV-positive prisoners, but this has vanished.

Interview with a social worker

A drug free zone is implemented with 8 places since 18 months. Usually prisoners (both for drug addicted and alcohol addicted prisoners) might get into that ward 6–12 months before release. Thus it is designed as a pre-release programme, consisting of social skills training and lifestyle training.

The social worker sees no reason for drug testing, because of the high level of social control. As it is not a remand prison there are no physical drug dependence symptoms observed here.

As an important issue it is seen that the prisoners often lost their contacts to their families, children, and partners.

According to the social worker revolving doors effects can be noticed, because almost all prisoners return sooner or later to prison; they are already known by the guards. Abstinent treatment is the key approach.

Interview with a nurse

Two nurses and one doctor are delivering the health services, with a psychiatrist and a dentist coming in once a week. At the time of the visit there were about 17–18 patients in ARV treatment. The work with regard to HIV-positive prisoners is consisting of VCT, blood testing, covering information needs, provision of brochures. The HCV prevalence was estimated to be 50% – no treatment for HCV-positive prisoners is available.

The main health problems mentioned by medical staff were that prisoners are an extremely vulnerable group with apart from infectious diseases and drug addiction enormous dental health, and dermatological problems. A vaccination against HBV was offered.

Tattoos are seen as being out of fashion. TB was seen as being not a health problem, all prisoners are x-rayed. Benzodiazepines and barbiturates are prescribed by the psychiatrist once a week. Health care of children is a subject also for the mothers incarcerated.

The Ministry of Social Affairs is supervising the health care in Estonian prisons; complaints related to health care are also checked by them. They are also certifying prison health care to deliver health care.

According to the medical staff more doctors, more nurses are needed, because the work load is high, more medicine should be available.

The complaints are around missing appointments with doctors, the quality of food, missing tablets, or the main treatment not being received. According to the nurse in general complaints are not very often.

Focus Group: Seven female prisoners in DFU

According to the majority of respondents the most widespread drug in prison is fentanyl. The price and the quality are the same as outside. In prisons there are different ways of consumption: injecting, smoking and snorting.

According to the focus group members approx. 90% of the prisoners are drug users. Getting drugs and needles is difficult in Harku prison. Thus drug use happens only on special occasions, and not on a permanent basis.

The drug free zone is perceived as a privileged living area (with some extras, e.g. refrigerator) one has to apply for. However, this requires an outing as a drug user. But because almost all prisoners are supposed to be drug users, this doesn't play an important role. It is possible to go there 6 months before release. The rule is that if three times misbehaviour is happening, prisoners have to leave the unit, but this has never happened. The living conditions are substantially different to a dormitory for 16 prisoners. There are three rooms in the DFU area: 2 x 2 and 1 x 4 prisoners. Prisoners of the DFU see the other prisoners at school, work, churches and special performances.

Regarding sharing of needles, those who are supposed to be HIV-negative take their own needles, those who are positive share their equipment with others.

For ARV treatment an infectiologist is urgently needed, more information about effects and side effects of ARV is required, as well as more involvement in decision making (e.g. start of a therapy).

A special problem is seen in the fact that on week-ends (from Saturday to Monday) no doctor or nurse is available. Ill treatment, allergic reactions, dermatological problems, work dust – patients with all these problems are being sent to the prison hospital. A problem named by several prisoners is the fact that the medication often is not available in the prison after coming back from hospital. Sometimes medication known from outside or the prison hospital is not available in prisons e.g. a special diet. Sometimes the mode of consumption of medication can not be kept. Often no pain killers are available.

A need for more vitamins is expressed by the inmates. Due to financial reasons vitamins are supposed to be cut. No fruits are available; also vitamins can not be bought separately, only garlic, and onions. Vitamins are seen as a key health issue by the prisoners; they think that fruits contribute to strengthen their immune status substantially. Prisoners in the DFU have refrigerators, so they can buy food in advance.

Regarding ARV-treatment more information is needed. Information given to the prisoners is often difficult to understand for them, a ‘difficult subject’, which often needs to be translated by Convictus health workers. Some prisoners feel being pushed to treatment. For the first two months in ARV-treatment prisoners get extra food.

Respondents express their concern that sometimes the opinions of the doctors are different and contradictive. Out of the seven respondents five are in ARV-treatment.

There is a long waiting list for visiting the dentist. As he/she is coming in only once per week for 2.5 hours there is a long waiting list. Only if 80% of the teeth are missing there is a payment and repairment provided. Prisoners are often ready to pay for it, but this is impossible due to technical details.

The psychiatrist is not providing treatment. He/she prescribes strong drugs, where prisoners never know which medicine is in there. Proper information about barbiturates etc. is missing.

Regarding the psychologist patients express the lack of confidentiality. Patients express their concern that the content is communicated to other persons.

Although there is drug use happening from time to time OST in prisons is perceived as not necessary. Basically the respondents feel well living and

staying ‘drug free’. However, many respondents report relapses into drug use again shortly after release.

The Narcotics Anonymous (12 steps programme) is coming into prison. Once a month Convictus is sending a nurse. The needs of women are different to men, e.g. shopping list is male oriented. The female respondents want to be female in any way, also in prisons.

4.1.2.3 Tallin prison

Chief nurse Tallinn prison

In prisons electronic files about patients are kept, using the same software “e-patient” as outside in the community used by family doctors. The goal is to make it suitable to the outside programme and completely connect it with that.

On the first of November 2008 there were 225 HIV-positive prisoners in Tallinn, of them 56 in ARV treatment. 80% of HIV-positive prisoners are Non-Estonians.

The MoSA is paying for ARV treatment. Furthermore the MoSA Health Care Board checks the quality of medical care in prisons by visiting the prisons.

According to the chief nurse the three main diseases of prisoners are:

- stomach problems,
- haemorrhoids,
- dental problems.

For HBV/HCV no treatment is available yet. HBV-vaccination is offered only for members of risks groups of more than 7 months imprisonment.

For incoming prisoners in the first 24 hours prisoners are seen first by a nurse then by doctor if needed. The nurse has a list with all health problems. There is the offer of HIV-testing for every incoming prisoner: a specialist nurse is doing pre- and post test counselling.

Self harm is widespread for prisoners being in pre-trial for longer time. Nurses and staff already know those who are at risk for cutting. According to the nurse cutting is done for various reasons mostly in order to receive certain advantages, medication as wanted, appointment with the doctor etc.

According to the nurse the results of the above mentioned study⁵ show that consensual sex on an emotional basis does not happen between prisoners, sex is mostly occurring within prostitution relationships, there are few rapes. Condoms are only laid out in conjugal visit rooms and not in the medical unit.

According to the nurse tattoos are a big issue in prisons. If tattoos are discovered the security department is being informed.

According to the nurse a co-operation model has been implemented: prisoners are sent to outside doctors for e.g. combination therapy. Most of the prisoners continue ARV after release. Benzodiazepines as a therapy are prescribed by psychiatrists, 90% in remand.

21 IDUs are on waiting list for Tartu prison, which developed an expertise in drug treatment. According to the nurse the drug detoxification procedure is as follows: symptomatic treatment by using painkillers, benzodiazepines and sleeping pills.

According to the interviewee health care in prison is valued much better in prisons than outside in the community: “It is a matter of availability of services.”

In 2004 a working group has been established to check whether prison health care can be delivered by outside agencies. It was estimated that 10 Mio. EEK more would be needed.

One of the key problems is that the prison department does not find doctors for prison posts; several posts are not covered at the moment.

Focus group with nine male prisoners

The prisoners complain that for the last 1.5 months no HIV testing or virus load check has been conducted. Furthermore no vitamin tablets, no vaccination, no additional food is given – there is no money left for that.

According to the prisoners of the focus group drugs are not available that easy, there are certainly prisons where they are more easily available.

Prisoners do not use drugs on a permanent basis; drug use depends on accessibility and availability. However if it occurs and if the drugs are taken intravenously, some 15 prisoners are sharing the needle. This might happen for

5 By University of Tartu

more than two months. The sharpening of the needle is done by using the window glass. Those who are HIV-negative are boiling the needle for some minutes, the rest is sharing. According to the prisoners nobody cares for infections once the drugs are in. Their estimation about the spread of drug users is between 60–80%. Asked if there is a sharing of drugs and injection equipment, prisoners state that everybody is sharing the same spoon and syringe as there is just one syringe. Other everyday items, like razor blades, scissors etc. are not shared.

Porn magazines are forbidden in prisons, during a raid of special armed forces at the day of the interview several magazines have been confiscated.

Almost all prisoners are tattooed. Everyone has his personal needle. According to the prisoners this is the least likely mode of transmission of infectious diseases.

The prisoners state that the health care service in Tallinn prison is perceived as deficient. The following problems are named:

- refusal of medicine
- advice of taking hot tea (advice given during the last 3 months)
- tablets are given out of one jar, several prisoners with different symptoms get the same medication, (“80% get it out of the same jar, for the remaining 20% the jar is shaking”)
- problematic access to specialist doctors (three prisoners in the group are HIV-positive; they wanted to see an infectiologist).

Furthermore it is being reported that sometimes it is impossible to take the medicine at the same time of the day.

One prisoner reported that he has been sent to an isolation cell (carcer), and has not received his ARV-treatment for 4 days.

The prisoners also state that side effects of ARV treatment are not sufficiently discussed no education about that, except by Convictus members. The doctor informs about ARV treatment but often this is not understood by the prisoners. According to prisoners in the focus group the adherence to the therapy would be higher if patients understand everything.

According to the prisoners in the focus group OST should be introduced in the prison. The continuation of OST by the Central prison has been stopped in early 2000.

A lack of doctors is perceived. NA is working in the Tallinn prison with their 12 step programme. A pre-release treatment is demanded by the members of the focus group.

Head of Social Services

The social service consists of 25 staff members for a prison of approx. 1,100 prisoners (seven social workers, five psychologists, five chaplains, one leisure time specialist, one specialist for formal education/vocational training, and other specialists).

The staff members elaborate a risk/needs assessment after punishment, which is valid for one year as an individual sentence plan. The most actual risks are prioritised. Highest risks come first. After one year the risks are re-assessed, and the treatment plan is being adjusted. In the units on the wards there are “personal officers” who assist in keeping the goals in the treatment plan, they try to motivate prisoners to achieve the goals set up in the plan.

Risk assessment is going to be raised in special sessions and trainings conducted also by medical service: doctors are giving lectures.

The social service is mainly working with two programmes:

- lifestyle programme (offer alternative lifestyle models)
- social skills programme (e.g. deal with anger adequately).

Lifestyle training is the outcome of an EU-twinning project with TRIMBOS Institute in Utrecht in The Netherlands a few years ago. The major goal is to work with different people by keeping in mind different capabilities of the prisoners and adjustment of treatment goals to this. Each of these programmes has its own manual to deliver tools to reduce risks.

Most of the social workers and psychologists are trained for these two above mentioned manualised training and treatment programmes. They start with group work and then move over to individual work.

They also cooperate with other and external support groups (e.g. Convictus, NA, until recently also with AA).

In case of a conditional release the treatment plan is elaborated for the court. According to the social worker conditional release is increasing, which is also possible for IDUs, especially since February 2007, when electronic monitoring and surveillance has been introduced.

Probation and prison officers work with the same software since summer 2008, so that everyone can see, what has been agreed upon, which aims are envisaged, and what has been achieved so far. Probation services are allocated to prisons in three different areas: Viru, Tallin and Tartu.

The probation service as well as the staff in prison is trained on the continuation of ARV treatment in the community. Convictus is offering two support groups for remand and sentenced prisoners both in Estonian and in Russian (altogether four groups).

Strengths and weaknesses

What has been achieved in Estonian prisons is that HIV-positive prisoners are no longer separated and thus discriminated. A process of normalisation in dealing with the disease can be observed.

Counselling is happening by integrating external NGOs such as Convictus, who conduct support groups in Estonian and Russian language.

Diagnostics and assessment seem to have a high priority in Estonian prisons. All medical examinations and services as outside are in principal available.

According to the restructuring of the prison services with new prisons and a lot of new personal permanent training of the new and also old staff is needed in order to achieve a high level of knowledge and commitment. The health challenges are enormous, e.g. a high level of HIV-positive prisoners who need to be treated. Understandable counselling about advantages and side effects of ARV-treatment plays an important role with regard to understanding of and adherence to the treatment. According to the results of the field visit, this understanding needs to be developed in order to also improve the rate of continuation of ARV after release. At the moment Convictus seems to play an important role in 'translating' the advices given by the medical personal.

More contact and exchange between medical department and NGO might be fruitful for a better education and information of the patients.

HIV/AIDS and hepatitis B and C are not just medical topics. Repeated consultations are needed regarding decision making to start ARV treatment. The medical personnel interviewed does not see improved communication and education as an important point to be developed.

Furthermore a complex and comprehensive approach needs to be developed to tackling adequately the drugs and infectious diseases problems. Taking the commitments from the “Dublin Declaration” and the current practice a gap can be observed (Lines et al., 2009).

4.1.3 Results from inmates’ survey Estonia

4.1.3.1 Description of the sample

In Estonia 167 inmates answered the questionnaire. 45.7% (N=78) come from the Harku women’s prison, 36.5% (N=61) from Viru Prison, and 8.4% (N=14) each from Tallin and Tartu Prison.

50.3% (n=84) of the sample are men and 49.7% (n=83) are women. The mean age is at 29.9 years with a range from 19–56 years and the median at 29 years (N=167). Men are with a mean age of 28.9 years younger than the women with 30.9 years.

83.2% say, they are (or were) drug users (N=165). With 95.2% of the men but 73.3% of the women there is a significant difference ($p < 0.000$) concerning the status as drug user.

The vast majority at 80.8% speaks Russian as mother tongue (N=166), Estonian with 15.6%, 2.4% state both, and 0.6% each speak Romani and Tatar.

The education level is about the same for men and women. The largest group (35.3%) has completed primary school, while higher education is not common among the sample (see table 5).

Table 5 Level of education, Estonia (%), N=167)

	total	men	women
No formal education	1.8	1.2	2.4
Uncompleted primary school	12.6	14.3	10.8
Primary school	35.3	34.5	36.1
Uncompleted high school	11.4	13.1	9.6
High school	15.6	13.1	18.1
Specialized school/college	19.2	17.9	20.5
University	0.6	0	1.2
Other	3.6	6.0	1.2

Almost half of the sample is single, men more often than women, while only 10.2% are married and almost one third have a partner, women more often than men (see table 6).

Table 6 Marital status, Estonia (% , N=164)

	total	men	women
Single	41.9	51.8	33.3
Married	10.2	12.0	8.6
Having a partner	29.3	25.3	34.6
Divorced	13.8	9.6	18.5
Widowed	3.0	1.2	4.9

47.6% of the respondents do have children (N=164), of the men 29.3% do have children while 65.9% of the women do have children (p<0.000). The range lies between 1 and 6 children, the mean at 1.5 children (men 1.3, women 1.7 of those with children).

4.1.3.2 Imprisonment

The length of the current prison sentence often lies between 3–5 years (33.5%) and between 1–3 years (29.9%). Women have more often short sentences (up to one year) but there are also slightly more women sentenced to more than five years than men, although these differences are not significant (see figure 2).

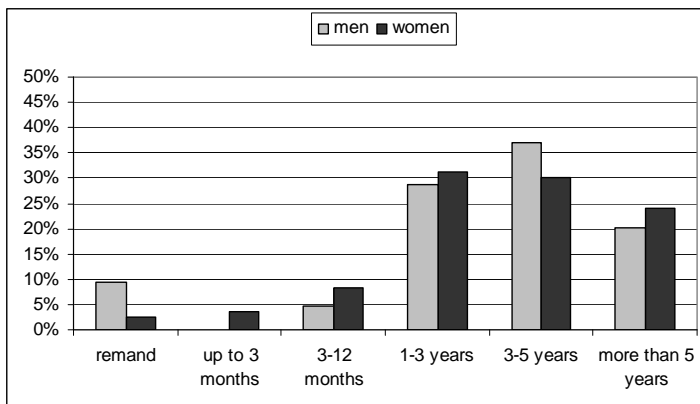


Fig. 2 Length of current prison sentence, Estonia (N=167)

Men have served more time of their sentence already than the women in the sample. Both have been in prison a substantial time already therefore being experienced with prison life.

Table 7 Stay in prison on this sentence until now, Estonia (% , N=166)

	total	men	women
3 months or less	7,2	0	14.5
3–12 months	18,7	16.9	20.5
1–3 years	56,6	62.7	50.6
More than 3 years	17,5	20.5	14.5

There is a significant difference between men and women on the prison time served during the last 10 years. Women having been less long time in prison than men.

Table 8 Prison time in the last ten year, Estonia (% , N=162)

	total	men	women
3 months or less	4.9	0	10.0
3–12 months	9.9	4.9	15.0
1–3 years	32.1	26.8	37.5
3–5 years	19.8	22.0	17.5
More than 5 years	33.3	46.3	20.0

The number of different prison stays (N=161) varies: The mean number is 2.5 times in the last ten years (men 2.9 times, women 2.1 times), median 2 times, range between 0 and 10 times.

The most problematic situations/circumstances in the prison are perceived by the prisoners as presented in the table below. There are significant differences between men and women concerning the issue ‘separation from children’ ($p < 0.000$), which is much more stressing for women. This is also due to the fact, that women do have children much more often than men. Differences, although not significant, also occur for ‘feeling depressed’ and ‘prison restrictions’ (see figure 3).

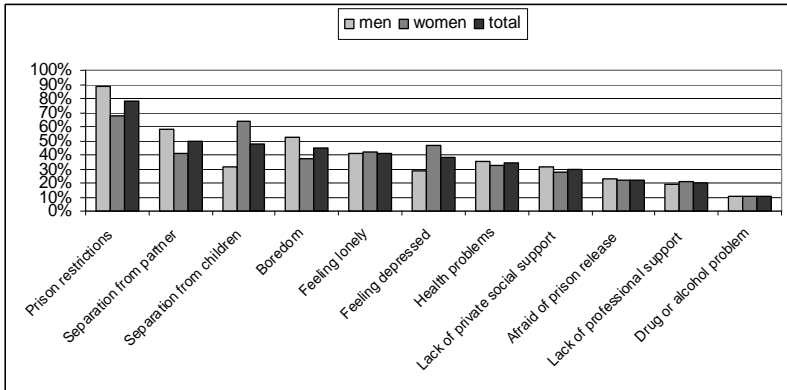


Fig. 3 Suffering from prison situation, Estonia (% , N=167)

4.1.3.3 Health

The physical health status was rated by the inmates better (59.4% very good or good) than their psychological status (46.6%). There are significant differences between men and women ($p=0.001$) concerning the psychological status which is rated much worse by women than by the men. This means women suffer psychologically more than men.

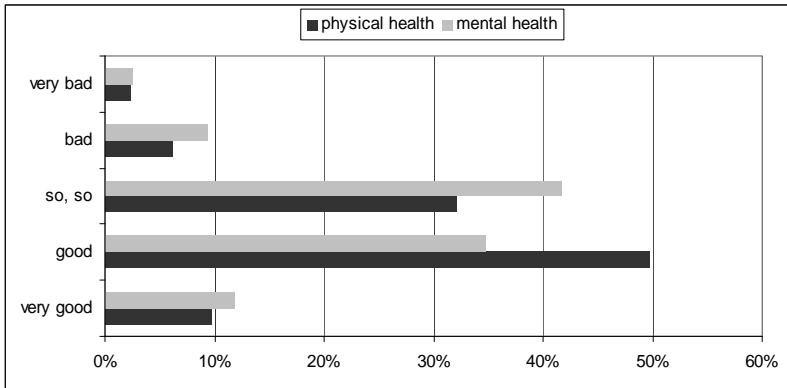


Fig. 4 Rating of own health status, Estonia (%)

The rates for HIV are very high in Estonia, 42.9% of all respondents reported to be HIV-positive (48.1% of men, 37.8% of women). This is much higher than the Estonian average rate in prison which varies between 10–20% (see chapter 4.1.1.2). This difference could be explained by the recruiting of interviewees which was done by members of the NGO Convictus. Convictus mainly works with HIV-infected people so they are likely to be overrepresented in our sample. Secondly only drug users were approached to answer the questionnaire, and among them HIV infection is higher than among all prisoners.

Concerning hepatitis C more than every second interviewee (51.9%) reported an HCV infection. There are significant differences between men and women ($p < 0.000$), the latter being less often infected with hepatitis C (33.2%) than men (70.4%). Women are also less often infected with HIV, but this difference is not significant (see figure 5).

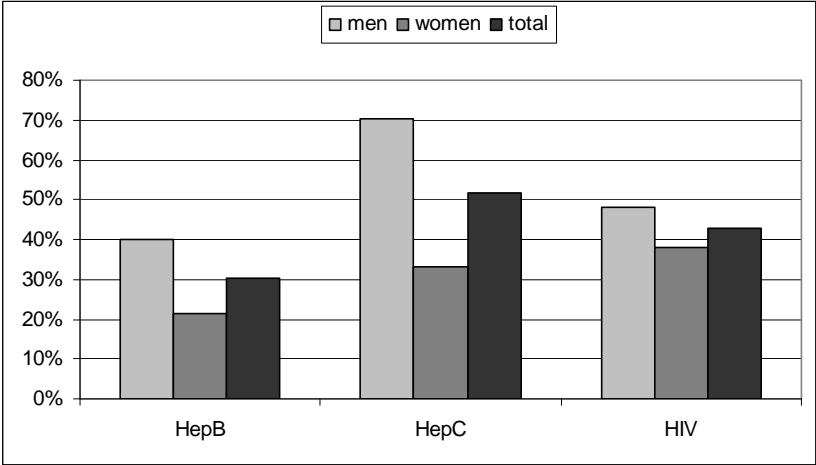


Fig. 5 HIV and Hepatitis, Estonia (%)

Hepatitis B is not as widespread as Hepatitis C with 30.3% and men being more often infected than women. But still these are high numbers, keeping in mind that vaccination does exist. Tuberculosis doesn't occur often in the Estonian sample (0.7%).

Treatment for HIV (N= 68 (1 missing) and HCV (N= 84 with HCV yes) – only those who are HIV/HCV positive (%), of those infected one receives antiviral treatment for HCV, whereas almost half of the HIV-positive prisoners receive antiviral treatment.

Table 9 Treatment for HIV and HCV, Estonia (%)

	HIV antiretroviral treatment	HCV antiviral treatment
Yes, currently	48.5	4.8
Yes, terminated in prison	2.9	4.8
Yes, outside prison	4.4	9.5
No, never	41.2	79.8
Offered but refused	2.9	–

Inmates suffer from a number of health problems. The most prevalent are sleep disturbances and depression (see table 10). Both might be due to the prison situation as such. Furthermore respiratory problems are mentioned to a certain degree, other diseases and symptoms are only mentioned by a few each. With 43.1% of all respondents a significant group states to have no health problems, but women state this to a lesser degree than men.

Table 10 Other diseases in the last 30 days, Estonia (%; N=159)

	total	men	women
Sleep disturbances	44.7	41.6	47.6
Depression	42.8	41.6	43.9
Respiratory problems	16.4	19.5	13.4
Drug-related overdose	1.3	0	2.4
Hepatitis A	0.6	0	1.2
Sexually transmitted infections	0.6	0	1.2
Other	7.5	3.9	11
no health problems	42.1	46.8	37.8

Other health problems that were mentioned include the following (each named by one respondent, hypertonic by two):

- injury
- allergy
- bladder infection
- depression
- fever
- headache
- haemorrhoids
- high blood pressure
- hypertonic
- pain in feet/leg
- psychosis
- stomach pain.

4.1.3.4 Drug use

We asked the inmates for estimations on drug use in prison. Although the answers for the different substances almost always range between 0–100 per cent (and not many giving estimations at all, as most say they could not estimate this), there are differences in the mean percentage. Benzodiazepines are rated to be the most often used substance, followed by amphetamines (see table 11).

Table 11 Estimations on drug use in prison, Estonia

	Mean Percentage	Range Percentage	Don't know (% of all)
Benzodiazepines (N=58)	40.0	0–100	62.9
Alcohol (N=34)	30.4	0–100	76.0
Amphetamines (N=31)	29.3	0–100	77.8
Cannabis (N=31)	28,5	0–100	79.0
Heroin/Opiates (N=31)	21.5	0–100	77.2
Ecstasy (N=28)	19.1	0–100	79.6
Methadone/buprenorphine (N=23)	17.6	0–100	80.8
Cocaine (N=26)	10.8	0–80	80.2
Poppy straw (N=25)	7.6	0–50	81.4
Crack/Freebase (N=23)	2.0	0–20	81.4

Almost one third (30.1%) of the respondents (N=156) has been checked for drug use, and two thirds (67.6%) reported own drug use (N=148), with no significant differences between men and women.

It is remarkable that the numbers estimated for drug use in prison are notably higher than the percentage of the use of the respondents. But the estimations above and the drug use in prison by the respondents (see figure 6) show almost the same order, benzodiazepines, cannabis, amphetamines and alcohol being the most commonly used substances in prison.

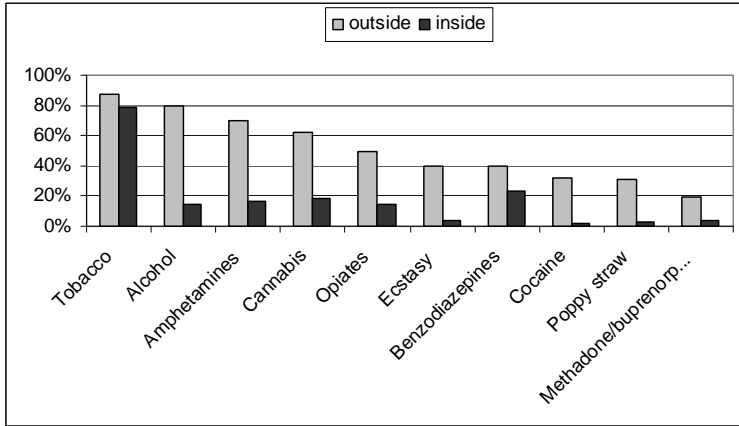


Fig. 6 Own substance use, Estonia (% of all 167)

Although the number of respondents to the question regarding routes of administration is rather low, the mode injection is dominating the use of heroin, crack/cocaine, and amphetamines.

The acquisition of drugs in prison is mainly perceived as rather difficult or very difficult (84.8%) and only 15.2% rating the acquisition as very easy or rather easy (see figure 7). Women rated it slightly more difficult although not significant.

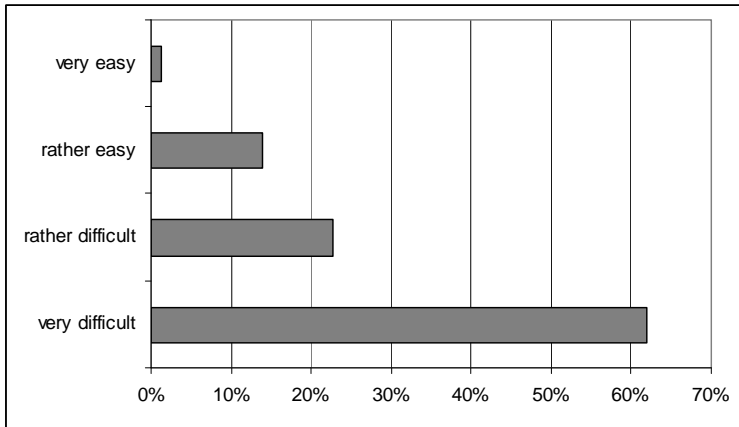


Fig. 7 Acquisition of drugs in prison, Estonia

There are some differences between men and women. Women use less often drugs in prison, but outside prison they use about the same as men, depending on the substance (see figure 6). They also estimate it more difficult than men to acquire drugs in prison. This could be explained by the assumption that women take the time in prison more often as a break from drug use, therefore not so much effort is made to get drugs into prison.

4.1.3.5 Risk behaviour

81.5% of the sample report not-injecting in prison (men 67.6%, women 94.8%). There are significantly more men than women injecting ($p < 0.000$). Correspondingly significantly more men (28.4%) than women (3.9%) report multiple uses of their syringe, which can result in health problems like abscesses or thrombosis. Moreover syringe and equipment sharing with other people increases the risk of transmitting communicable diseases. Syringe or equipment sharing inside prison is reported by 3.7% often and 17.8% with 'every now and then' (N=107). Outside prison these percentages are higher with 5.8% of the sample (N=138) reporting it often and 31.2% 'every now and then'.

Concerning sexual violence and physical violence in prison the difference between men and women is significant ($p < 0.000$), men rating the occurrence of sexual violence being higher than women do. Also physical violence occurs much more often in men's prison than in women' prison, while for psy-

chological violence there is no difference. The high percentage of respondents stating not to know about violent behaviour in prison (64.2% for sexual, 40.9% for physical, and 21.3% for psychological violence), especially for sexual violence, could indicate a reluctance to give information on the issue, and therefore to seem involved with it.

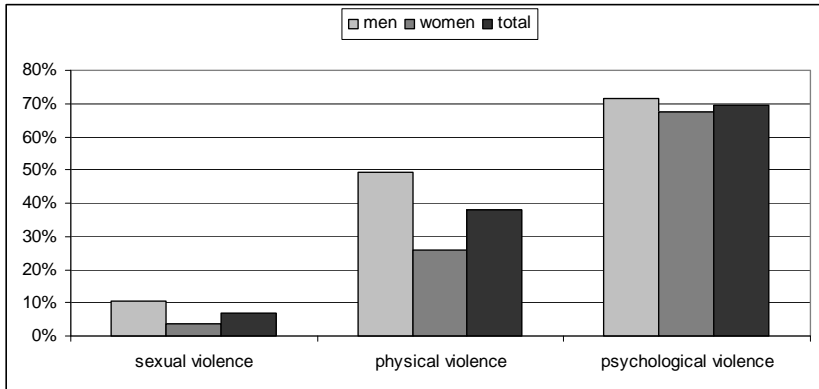


Fig. 8 Estimations on violence occurring in prison, Estonia

Similarly for estimations on sexual contacts the majority of prisoners (more than 80%) state to not know, even more so, if forms of rape or prostitution are concerned. Those few estimating the percentage of how many prisoners have sex in prison (N=23) give an average estimation of 20.0% of prisoners engaging in this, for “paying for having sex” (N=19) the estimation is 10.0% of prisoners, and for rape (‘sex against somebody’s will’) (N=13) it’s 1.6% estimated. In contrast the proportion of prisoners receiving long-term visits is estimated at 35.9% (N=50). This last issue comes close to the experience of the sample on conjugal visits, with 29.3% (N=164) reporting conjugal visits (34.0% of the men, and 24.1% of the women).

Concerning other risk behaviour, tattooing takes place significantly more often among men than women ($p < 0.000$), while the other risk behaviour does not differ significantly.

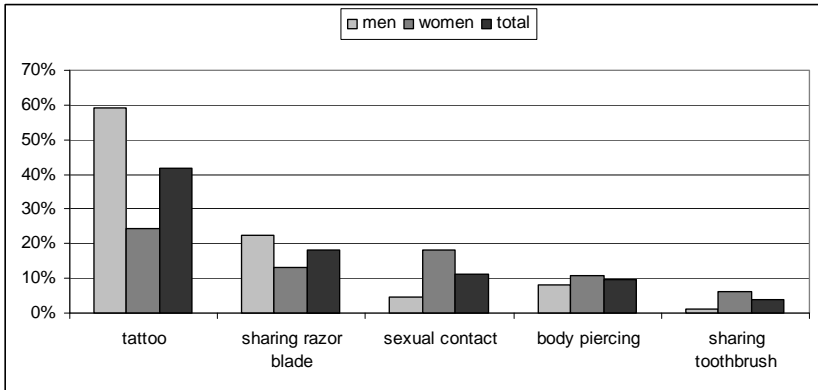


Fig. 9 Risk behaviour, Estonia

4.1.3.6 Help Services

No one in the sample is in prison-based substitution treatment, while 10.6% were in substitution treatment outside prison. 1.3% report a detoxification treatment in prison, while 8.1% did undergo detoxification with medical help outside prison already.

The following figure shows, which services are available according to the inmates and which should be available (some respondents answered both with 'yes' within one service. Therefore answers might add up to more than 100%.)

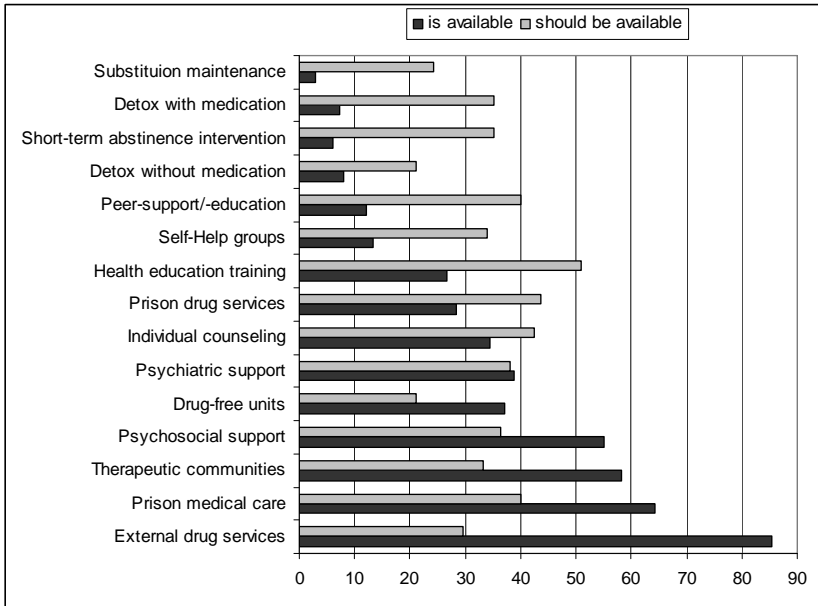


Fig. 10 Service availability, Estonia (%)

Other services mentioned as available were (each named by one respondent, except family courses, by two):

- cigarettes
- family courses
- family support groups
- infectiologist
- interesting people
- more information and involvement
- opportunity to study
- self-help group
- social courses
- spiritual programs.

When asked for the services they had used in prison, only few inmates answered, therefore it's not possible to distinguish between men and women for this item (see figure 11). Although four prisoners state to be in OST or have been in prison, this is not possible as OST is not offered in prison. It is

likely that some inmates misunderstood the term “ever used in prison” for “ever used”.

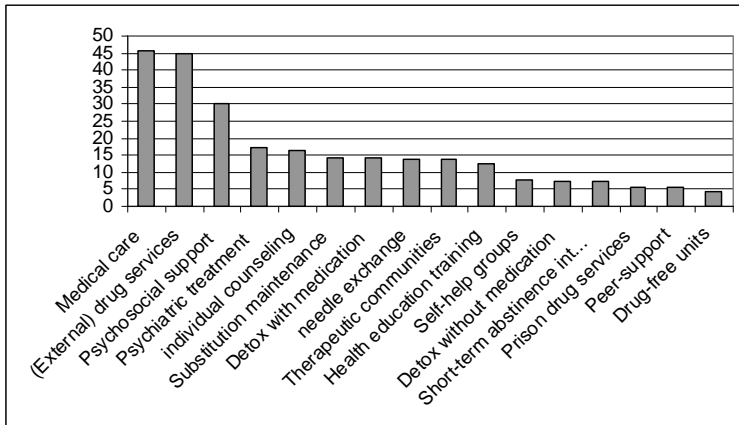


Fig. 11 Service use in prison, Estonia (%)

Outside prison, drug users do use services to a higher extend at least occasionally; especially counselling and medical services and also more low-threshold facilities are visited.

Further remarks on which other services they find important can be divided into two groups: General needs concerning the prison life and restrictions generally, and those needs about health care. Results are presented for men and women separately.

Table 12 Service needs of men, Estonia

concerning health care	Concerning prison generally
Infectionist/without queue (5x)	Excercise, sports, gym (20x)
Medical care (5x)	Rehabilitation (9x)
Psychologist (3x)	Fresh air, ventilation (4x)
Dentist (2x)	Library, more books (3x)
Doctor in time/without queue (2x)	More fruits, vitamins (2x)
Accessibility of doctors	12-steps rehabilitation
Books on drug dependency	Convicted for drug dealing kept separately

Dermatologist	Convictus
Drug dependency specialist (psychologist)	Debts advice
Drug dependency rehabilitation	English course
More information on drug dependence	Help to improve/build relation with family
ophthomologist	Information / help for release
Personal therapeutic approach	Lectures
Psychologist as former drug user	More activities
Syringe exchange	More TV channels in Russian language
	One should not feel being in prison
	Possibility to study at university
	Spiritual rebirth
	Social help
	School
	Various groups

Table 13 Service needs of women, Estonia

Concerning health care	Concerning prison generally
Psychological support (5x)	Rehabilitation (4x)
Infectiologist (2x)	Computer courses (3x)
More information on drug dependency (2x)	Possibility to study/learn (3x)
Psychological help for drug dependency (2x)	Social training (3x)
Regular blood test (2x)	Consultation on any topic (2x)
Blood cleaning	Help for release/rehabilitation (2x)
Communication with drug addicts who are clean	More psychologist help (2x)
dermatologist	Purposeful activities (2x)
Drug withdrawal	Rehabilitation work (2x)
First aid	Sport (2x)
Gynaecologist must be a woman	Adequate rehabilitation
methadone	Convictus
More health care	Discover gifts and talents

Movies about damage of drug dependency	Juridical consultation
First aid	More care(ing)
Gynaecologist must be a woman	More communication with relatives
Psychiatrist without waiting list	Self-help
Young psychologist	Yoga
	Vocational advice

Although an individual treatment plan is supposed to be organised for every prisoner (see Quaker Council for European Affairs, 2007), the majority of respondents doesn't have one (47.1%) or doesn't know of it (37.3%). This means, 15.7% report to have a treatment plan, while 27.1% applied for a treatment plan. 20.4% of the sample do get assistance for prison release. This seems to be a small number, but not all inmates interviewed are close to release therefore assistance might start later.

When rating the quality of the treatment offered in prison, the majority of inmates rate it rather bad or even very bad. It is remarkable that the medical service is rated worse than social services.

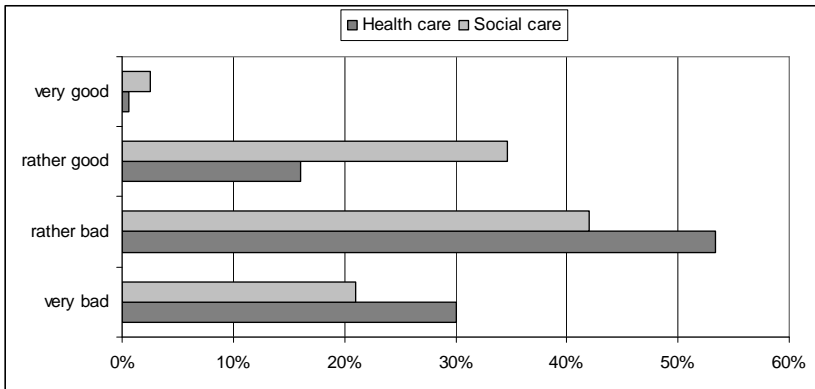


Fig. 12 Assessment of quality of treatment, Estonia

4.1.4 Results from the presentation of the results in Estonia

The results of the research were presented in Estonia on the 9th of March 2010. Participants were representatives from the Prison Department, from the prisons visited and representatives of NGOs.

The results of the quantitative study have been presented by a slide – based lecture and then discussed. First of all recent developments have been discussed.

Recent developments

It has become clear that a lot of changes have happened, since the CONNECTION study has been carried out: First of all the numbers of prisons and prisoners have been reduced; 3,470 prisoners in five prisons:

- Tallinn Prison (max. security prison with cells, 1,062)
- Prison Hospital (30)
- Viru Prison (new max. security prison with cells, 963)
- Tartu Prison (new max. security prison with cells, 924)
- Murru Prison (max. security prison with dormitories, 288)
- Harku Prison (closed prison with dormitories, 203)

More important the prison reform has made substantial progress:

- Old camp-type prisons have been closed (Pärnu, Viljandi and Ämari)
- In 2008 the new Viru prison opened
- The old Murru will be closed soon
- A new prison in Tallinn will be opened in a few years
- The process of reducing the prison population will be continued (now: 259 per 100,000 inhabitants)

These developments intend a higher specialisation of the prisons, although generally the principle of locality is followed:

- Tartu prison
 - Special unit for male drug addicts (174+55 places), including rehabilitation and post-rehabilitation department
 - Psychiatric department
- Viru prison
 - Convicted male prisoners for drug crimes
 - Male minors
- Harku prison
 - Convicted females and male prisoners over 57 years old
- Tallinn prison
 - High number of people held in custody

- Murru prison
 - Male sex offenders and low-risk prisoners

Also on the level of national policies progress has been made in drafting concrete plans:

- National drug prevention strategy until 2012 and the action plans
- Strategic goal for prisons: a holistic control system exists to avoid drugs getting in the prison; systematic drug treatment and rehabilitation are available in prisons
- National HIV/AIDS strategy 2006–2015 and the action plans
- Strategic goal for prisons: HIV does not spread in prisons
- Drug prevention strategy for prisons (Ministry of Justice 2008, 2010)
- Drug prevention principles and guidelines for prisons
- ‘Treatment instead of imprisonment’ the new law has passed the first reading in Parliament

Recent data provided by the Prison Department (Medical departments statistics) show that 28% of the male and more than 50% of the female prison population are considered to be drug addicts (see data of the prisons in table 2).

Data from another study (focus groups) show that prisoners perceive the drug users proportion much higher than the present study:

- 90% drug users among women
- 60–80% drug users among men

Introduction of drug addiction rehabilitation programmes

Risk assessment and individual sentence plans

Drug rehabilitation departments in several prisons:

- Special unit for drug addicts in Tartu prison (174 and 55 places)
 - Pharmacotherapy and abstinence based approach
 - Waiting list
- Viru prison (20 places for minors and 20 for adults)
 - abstinence based approach
- Harku prison (8 places for women)
 - Abstinence based approach
 - Short-term interventions
 - Life-style training, social skills training, 12 steps, NA.

Methadone Maintenance Treatment (MMT)

Regarding the treatment of prisoners it is noteworthy that MMT has been introduced in Estonian prison. MMT prior to imprisonment will be continued, and in the prison of Tartu MMT can be started. The cases of recent years are as follows:

In 2008:

- 2 cases of detoxification with methadone
- No MMT

In 2009:

- 4 cases of detoxification with methadone
- 8 cases of MMT

In 2010 1st quarter:

- 6 cases of detoxification with methadone
- 4 cases of MMT

The aims to be achieved according to the National Strategy Action Plan are as follows:

2010 – 25

2011 – 50

2012 – 75 prisoners should receive methadone treatment.

There have been problems encountered with the continuation of MMT. MMT treatments are being stopped in arrest houses. To solve this problem, with a grant of the UNODC the pilot of MMT in Tallinn and Viru arrest houses started on 01.04.2010.

Negative attitudes among the prisoners are being reported:

- Previous bad experience
- Stigmatization
- Female prisoners do not see the need for it (*focus group interview in Harku prison*)

HIV Prevention and Treatment

The following data regarding the situation about HIV have been presented by the Prison Department:

- 14% of all prisoners are HIV positive
- Voluntary HIV testing on arrival and after 1 year

- 6,223 tests done in 2009
- Refusal rate under 1%
- In 2009 87 HIV positive were diagnosed on arrival
- In the last few years no positive cases were diagnosed in the prisons
- Pre test and post test counselling: 5,089 counselling done in 2009
- ARV treatment: available to all HIV pos prisoners, financed by MoSA
- Various health care services.

Hepatitis B and C

Voluntary testing of risk groups (IDUs, HIV pos., prostitutes etc.)

- 219 HBV and 263 HCV tests were carried out in 2009
- No accurate overview available
- Study results show that 30% have HBV and 52% HCV

Pre and post test counselling

Voluntary Hepatitis B vaccination of risk groups and prison officers

- Before 2009 there was the 7-month criteria for the imprisonment length
- In 2009 219 vaccination for prisoners and 202 for prison officers were performed
- In 2010–2012 it is planned to vaccinate 500 prisoners each year

Hepatitis C treatment

- Financial obstacles, only continuation (1 case in 2009)

On the meeting it has been discussed intensively that more attention has to be paid to the spread, prevention and treatment of hepatitis B and C. Especially the policy and practice of HCV-tests need to be developed, HCV-testing should be recommended to all prisoners and should be part of the general medical examination on entrance.

4.1.5 Conclusions

The epidemiological situation regarding the prevalence of drug addiction, HIV, HCV and other BBV infections in Estonian prisons is very serious. Recent data provided by the Prison Department (Medical departments statistics) show that 28% among the male and more than 50% of the female prison population are considered to be drug addicts. 14% of all prisoners are HIV positive. Regarding HCV no accurate overview is being elaborated until now, however, study results show that 30% of the prisoners are HBV-positive and 52% HCV-positive.

The prison administration, respectively the Ministry of Justice have reacted to these challenges and to the living conditions of Estonian prisoners in general. In the last years enormous efforts have been made to build new single cell prisons, and the number of prisons has been reduced – old camp-type prisons (Pärnu, Viljandi and Ämari) have been closed. With that the number of prisoners has been reduced substantially (now: 259 per 100,000 inhabitants, compared to 351 in 2001). At the same time a higher specialisation of the prisons has been achieved (e.g. Tartu prison offers now a special unit for male drug addicts (174+55 places), including rehabilitation and post-rehabilitation department; Viru prison offers 20 places for minors and 20 for adults). Although with a very low number of cases, methadone maintenance treatment of prisoners has been introduced. A MMT treatment prior to imprisonment will be continued in the prison of Tartu. Also on the law making level a substantial change is envisaged: ‘treatment instead of imprisonment’ (the new law has passed the first reading in Parliament). This development is embedded in the National drug prevention and HIV/AIDS strategy and action plans (strategic goal for prisons: HIV does not spread in prisons).

Good examples can be found in Estonian prisons regarding diagnostics (except HCV), consultation, and the fact that all examination as outside are carried out. More or less all services are supposed to be available as on the outside. According to prisoners and staff views it has been achieved that HIV-positive prisoners are no longer discriminated and separated, and well accepted forms of counselling are happening (diary for HIV-positive prisoners to note all the laboratory data; e.g. Convictus, Estonia).

Despite all efforts the reactions towards the high burden of health challenges need to be scaled up with more speed and intensity. The evidence-based drug intervention strategy of pharmacotherapy with methadone or other agents needs urgently a higher coverage. 6 cases of detoxification with methadone and four cases of MMT (in the first quarter of 2010) is not enough to make optimal use of this very effective drug addiction intervention.

The UNODC provided a “Comprehensive Package” – as a reaction towards HIV epidemics – which needs to be applied in all details in order to make a difference to the current mostly abstinence-oriented approaches.

More attention has to be paid to the spread, prevention and treatment of hepatitis B and C. Especially the policy and practice of HCV-tests need to be developed, HCV-testing should be recommended to all prisoners and should be part of the general medical examination on entrance.

Both pharmacotherapy and abstinence-based approaches are an important element of pre-release treatment. Special approaches for women are needed as the spread of drug addiction and HIV is extremely high in this most vulnerable population.

Other future challenges are treatment forms for the increasing number of poly-drug users and sufficient prison-community linkages to establish a throughcare.

4.2 Hungary

4.2.1 General information on the prison system

In Hungary 31 prisons are operating (Hungarian Prison Headquarter, 2008).

4.2.1.1 Prison statistical data

In Hungary 14.911 inmates in 34 institutions were imprisoned in 2008 (Walmsley, 2008b), which makes a prison population rate of 149 prisoners per 100,000 inhabitants. More than a quarter of the prisoners (28.9%) are pre-trial detainees/remand prisoners. The occupancy level is at 118.5 per 100 places (Walmsley, 2008b). Therefore Hungary has a higher imprisonment rate than the EU average but less than other Eastern European countries (Council of Europe, 2007). Compared to 2005, the prison population rate of 2006 decreased by 4.5% (Council of Europe, 2007).

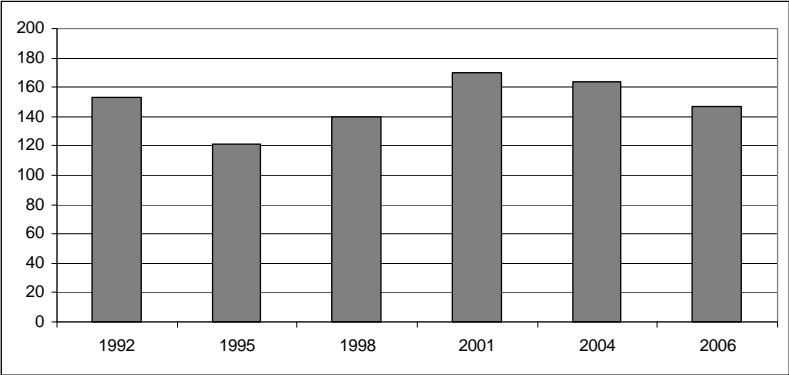


Fig. 13 Imprisonment rate per 100,00 inhabitants, Hungary

The mean age of prisoners was 34 in 2006. 3.1% of all prisoners were aged under 18, while 7.4% were between 18 and 21, which is both a little above EU average with 1.6% and 5.7% (Council of Europe, 2007).

In 2006 6.7% of all prisoners were female prisoners and 3.7% foreign prisoners (including pre-trial detainees), while 18.7% of the foreigners were pre-trial detainees (Council of Europe, 2007). The number of foreign prisoners was rising since 1993 (MacDonald, 2001).

Table 14 Length of sentence in 2006, Hungary (%)

Less than one year	16.8
from one year to less than three years	33.1
from three to less than 10 years	40
more than ten years	8.2
life imprisonment	2.0

(adapted from: Council of Europe, 2007)

The suicide rate per 10.000 prisoners was at 2.4 in 2005 and the overall mortality rate at 28.1, which was both below the European average (Council of Europe, 2007).

There are 304.4 prisoners per custodial staff (European mean 771.8, median 126). 8.2% of staff is treatment staff, which is less than the European mean at 10.6 (Council of Europe, 2007). Staff shortage is a problem in some prisons, where only 80% of jobs are filled, and often with new and inexperienced staff in the majority (MacDonald, 2003). Some improvement was made during the last years; in 2008 the staff capacity was at 96.4% according to official numbers (Fliegauf, 2010b).

In 2006 there were 2,448 persons sentenced for drug related offences (2005: 1,924). These offenders committed 2,874 offences which they were called to account for on the following legal grounds:

- 1,806 offenders were sentenced for “using type” offences;
- 182 offenders were sentenced for “trafficking type” offences;
- 148 persons were sentenced for “using or trafficking type offence to the injury of a person under the age of eighteen or by using such a person”;
- 348 persons were sentenced for conducts (drug-addicted persons committing a using or trafficking type offence).

On these offenders with drug-related offences, the following punishments and measures were applied:

- 923 were sentenced to imprisonment: 424 were enforceable and 499 were suspended
- 151 were sentenced to perform work in the public interest
- 771 were fined
- in 639 cases individual measures were inflicted (Reitox National Focal Point Hungary, 2007).

Overcrowding is an issue in Hungarian prisons, the official occupancy level being at 118.5% (Walmsley, 2008b), but in some prisons it is much more; the Kalocsa women's prison had 170% occupancy in 2002, 170% in the Tököl juvenile prison and the Szeged high-security prison up to 200% (MacDonald, 2003). The CPT found a slightly relaxed situation concerning overcrowding during their 2005 visit compared to 2003, due to decreased number of inmates and newly build prison facilities (CPT, 2006: 27).

4.2.1.1 Prevalence of HIV, HCV, HBV, TB and drug consumption

In the Hungarian community drug use was increasing during the 1990ies as well as drug-related offences (Elekes and Kovacs, 2002); there were estimations in 2001 of 10,000 heroin addicts in Hungary (MacDonald, 2004), while a capture-recapture study found between 2,069–5,813 injecting drug users and opiate users in Budapest city between 2000–2005, which might be underestimated (Reitox National Focal Point Hungary, 2006). The life-time-prevalence of illicit drug use in Hungary was at 6.4% in 2001, but much higher among young people and mostly concerning cannabis (Elekes and Kovacs, 2002). More recent data from 2007 show the number of 9.3%, which indicates an increase in this time period. The 12-month-prevalence is at 2.6%, and the 1-month-prevalence at 1.3% (Reitox National Focal Point Hungary, 2008).

Drug use in prison seems to be rather low and mainly concerning cannabis and testosterone, injecting being rather unusual, according to staff and inmates in Budapest Central Prison (MacDonald, 2004). There are 9–10 convicts annually with severe withdrawal symptoms coming into prison according to the Hungarian National Focal Point (Reitox National Focal Point Hungary, 2006). According to a report of the National Headquarters of the Hungarian Prison Service (BVOP), the use of anti-epileptic medicines has considerably increased in prisons in 2005. 12 times drug use was reported

among prison inmates. Six cases of morphine, 4 cases of ecstasy and 2 cases of cannabis use were registered (Reitox National Focal Point Hungary, 2006: 63). Another not yet published research shows that benzodiazepines, especially Rivotril® is widely used in prison settings (Takács, 2009a). Another commonly used drug in Hungarian prisons is a very strong tea called “dobi” (Takács, 2009b).

Table 15 Drug user in Hungarian prisons

	2005	2006	2007
Drug users (by selfstatement)	1,197	1,329	1,519
In medical treatment	264	258	191

(Hungarian Prison Headquarter, 2008)

The major drug used is only described for some of those drug users, as table 16 shows.

Table 16 Drug users in prison by substance, Hungary

Major substance	2005	2006	2007
Heroin	76	31	39
Cocaine	35	7	12
Amphetamine	35	84	71
Cannabis		94	90
Other opiate		5	2
Organic solvent	15	17	11
Other drugs		26	4

(Hungarian Prison Headquarter, 2008)

A research by Gyarmathy et al. found 49 persons out of their 632 sample to have used drugs in prison (117 outside prison), 1.3% of the females and 8.9% of the male inmates (2003). A study found in 2004 a lifetime-prevalence of any illicit drug use in prison of less than 10% and a 12-month-prevalence of around 5% (see Hedrich and Carpentier, 2009).

A new research among sentenced adult Hungarians on drug use was conducted in 2008. 43.8% of the sample reported lifetime prevalence of illicit drug use, 33.5% a last-year-prevalence and 25.7% a last-month-prevalence.

Cannabis is by far the most commonly used substance, followed by ecstasy, amphetamines and cocaine. The prevalence rates for women are significantly lower than for men. More men (35.0%) than women (11.5%) think it is possible to obtain illegal drugs in prison if they want to, the most common substances being cannabis, Rivotril and dobi. 14.3% of the sample used drugs inside prison, this corresponds to 29.4% of those with life time drug use experience. Almost half of the regular drug users outside used a substance inside prison. Again there was a significant difference between men and women; 15.0% of the men but only 1.2% of the women used drugs in prison. Inside prison, cannabis was the most commonly used substance, followed by ecstasy and amphetamines (Paksi 2009, cited in: Reitox National Focal Point Hungary, 2009). The prevalence of prison drug use increased between 2004 and 2008 (Reitox National Focal Point Hungary, 2009). The illicit use of benzodiazepines is very common on a daily basis inside many prisons. A high percentage (about 70%) of prescribed drug use (like benzodiazepines) also occurs in the youth centres where juveniles with social problems are held. Furthermore injecting steroids and using steroid and other pills is reported (Fliegau, 2010b).

Drug seizures in prison

The numbers of drug seizures in prisons are small as well. In Budapest Central Prison 8 – 10 drug seizures are reported per year (MacDonald, 2004). In 2005 there were 20 cases where officers mainly found pills containing MDMA and cannabis derivates hidden in packets or clothes of 21 persons (Reitox National Focal Point Hungary, 2006: 63). In 2006 21 cases with 23 persons involved occurred, mainly cannabis products were found, some amphetamine pills and once each cocaine and morphine (Reitox National Focal Point Hungary, 2007). For 2007 the prison administration reported 23 cases, where substances were found for all prisons. These were mainly THC and so-called low-level drugs; in 16 cases the drugs were found in parcels, the remaining were found in visitor rooms, cells or working places (Hungarian Prison Headquarter, 2008). Used syringes and needles were also found in prisons in a few cases, but as internal procedures do not require that these institutions report on such equipment found, there is no exact information available on their number (Reitox National Focal Point Hungary, 2006: 63). As the most common way of drug smuggling are parcels sent to the prison, the Hungarian Prison Service submitted a proposal on the limitation

of the number of packages prisoners may receive. This proposal necessitates an amendment of provisions (Reitox National Focal Point Hungary, 2006: 66f.).

Infectious diseases

Hungary began in 1993 to report on HIV infections, and prevalences are low. Only 0.4% of HIV infections of 265 (cumulative) cases in Hungary in 1997 were accounted for by drug use (Bollini et al., 2002). In 2001 963 persons in Hungary had reported HIV infection (Gyarmathy et al., 2003). In 2003 there were 17 cases of newly diagnosed HIV infections in Hungary among men, which is the lowest it has been since 1993. One of those cases was due to injecting drug use and 18 cases to heterosexual sex (Reitox National Focal Point Hungary, 2008). Still the numbers of HIV infections are low, with 119 new cases in 2007 and 81 in 2006, so increasing tendency can be assumed. Of those new HIV cases in 2007 were three due to injecting drug use, and all three were imported from abroad (Reitox National Focal Point Hungary, 2008).

The percentage of HIV-infected prisoners in Hungary was 0.03% of all prisoners, based on testing on admission (Bollini et al., 2002). There were nine known prisoners with HIV infection in 2003, they are held separately in Tokol prison (MacDonald, 2004). These small numbers might be the reason, why prison doctors did not consider the control of infectious diseases posing a problem during the survey in 1997–99, while mental health problems were considered important (Bollini et al., 2002).

Hepatitis C (HCV) infections are increasing in Hungary (MacDonald, 2004). In 2000 there was one acute case of hepatitis A, B, C each, and 113 chronic cases of hepatitis, 40% of them HCV (MacDonald, 2001). In 2007 IDUs were tested for infectious disease in 15 centres; there was no case of HIV, 25.7% had HCV antibodies and two persons (0.4%) had HBV surface antigens (Reitox National Focal Point Hungary, 2008). In 2006 nine cases of hepatitis C were diagnosed in the prisons on the evidence (Reitox National Focal Point Hungary, 2007).

Screening for Tuberculosis takes place in prison to large extends, in 2007 there were 11,761 people screened. The following figure shows the number of positive cases (Hungarian Prison Headquarter, 2008):

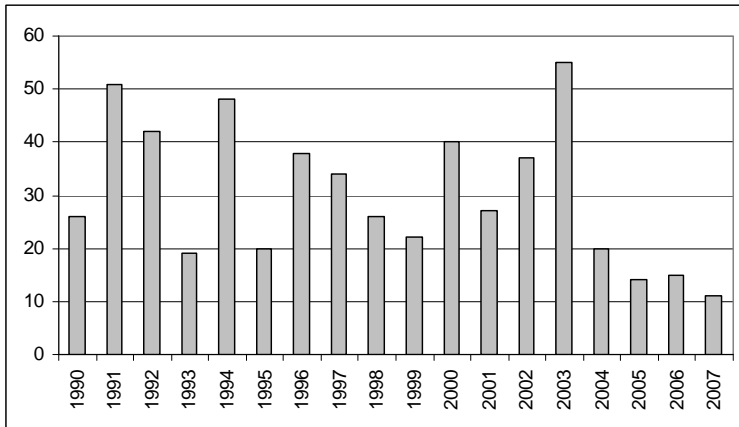


Fig. 14 Positive screening for TB in prisons, Hungary

The incidence of TB in Hungarian prisons is about 4–6 times higher than in the community (MacDonald, 2001).

Deaths occurred in Hungarian prisons according to the following figure:

Table 17 Cause of death among prisoners, Hungary

	2005	2006	2007
Tumorous disease	13	15	17
Heart and vascular system disease	23	19	20
Peptical disease	2	3	4
Disease of the respiratory organs	2	3	3
Suicide	4	5	5
Other	2		2
Total	46	45	51

(Hungarian Prison Headquarter, 2008)

Risk behaviour in prison

Sex in prison was reported by 10% of the study sample in a HIV education programme (Gyarmathy et al., 2003), and sexual activity seems to be more common among long-term detainees (Takács, 2009b). According to a qualitative research on risk behaviour in prison, tattooing takes place with some-

times blood-stained self-made machines, some users state that tattooing needles are shared, others deny this. Metal piercing is not very common, instead some prisoners make so-called penis-balls: little plastic balls made from toothbrushes are implemented under the penis skin. According to the reports of formerly incarcerated injecting drug users asked in qualitative research, due to overcrowding fights occur more or less frequently with sometimes rather severe injuries (Takács, 2009b).

4.2.1.2 National policies and strategies on drug use in prison

Hungarian drug laws are strict: where people are caught with drugs for their personal use they can receive a two-year sentence by law (MacDonald, 2004). In Hungary alternative treatment instead of imprisonment for drug users like detoxification in the community is available, therefore the number of drug users in prison was low at the end of the 90s (Bollini et al., 2002).

Since 2003 some legal changes did take place. A number of amendments were made to the Criminal Code, reflecting the legislation's perception of drug use and alternatives to prison (Reitox National Focal Point Hungary, 2006). For example, screening for HIV is not mandatory anymore. Since then not only addicts could choose 'diversion treatment'.

Drug users can be sent on probation by the court since 1993, to participate in a certain counselling (for non-addicts) or 'diversion treatment' (for addicts), as long as the person accepts to participate and fulfils the six month of participation (once a week). Since 2005, offenders on probation who cannot be diverted to alternatives to prison for any reason may also participate in a form of treatment (Reitox National Focal Point Hungary, 2006). But the law does not arrange what happens if a person is unable to undergo this treatment because of being incarcerated. Therefore, a drug treatment course for prisoners was developed by the prison service to attend, being equivalent to that in the community. The Forensic Observation and Psychiatric Institute (IMEI) does provide this treatment for prisoners (MacDonald, 2004).

Diversion programmes are available for three groups:

- treatment for drug-addiction
- other drug-related treatment (provided for e.g. non-addicted but co-morbid users)
- preventive-consulting services (Reitox National Focal Point Hungary, 2006).

The WHO guidelines on HIV and AIDS in prison (1993) have been partially implemented in Hungarian prison, according to Bollini (2002). These guidelines emphasize issues like treatment access to be equivalent to that in the community, confidentiality, voluntary testing and counselling, availability of prevention measures, non-discrimination of HIV-positive inmates (WHO, 1993). Separation of HIV-positive inmates still does take place in Hungarian prisons (Takács, 2009a).

Changes in the prisons' drug strategy took place since 2002, when they were "more a complexity of visions than a clearly formulated policy" (MacDonald, 2004: 76). Two years later the new strategy was an integral part of the National Drug Strategy, new initiatives like the drug-prevention units started.

4.2.1.3 Drug services

Due to overcrowding, shortage of staff and increased administration duties, there is concern that the personal approach which the prisoners need is stopped (MacDonald, 2004).

There are 9–10 convicts annually with severe withdrawal symptoms coming into prison. They are usually brought into the Institute for Forensic Monitoring and Mental Treatment (Reitox National Focal Point Hungary, 2006). Detoxification is usually done in police detention, before the inmates enter prison (MacDonald, 2001).

Prevention

Since 2003 a number of drug prevention activities have been carried out in prisons. The Hungarian Prison Service developed an educational documentary series of 9 video tapes that is shown to prison inmates in 3–5 weeks intervals in each prison. Discussions between educators and inmates take place in group activities. Approximately 6,000 prison inmates took part in the activities in the first three years. In prison schools, the transfer of knowledge about drug prevention, rehabilitation and health promotion is on the syllabus as well. These schools also employ drug coordinators in the course of their prevention work. Furthermore, in prisons for juvenile delinquents, there are possibilities for parents to organise meetings in which they are also informed about anti-drug activities carried out by the particular prison (Reitox National Focal Point Hungary, 2006). According to the Prison headquarters 204 inmates participated in prevention and information services in 2008 (01.01.–09.10.),

61 of them finished the treatment, 50 interrupted and for 93 it was still on-going (Hungarian Prison Headquarter, 2008).

Established by the National Equality Network a programme called “Busted” was carried out in the female prison of Eger since 2006, where 10–12 female prisoners aged 35–40 prisoners attended the programme weekly. This programme contained group training in skills development, self-knowledge and drug prevention (Reitox National Focal Point Hungary, 2007).

A research group offered AIDS education workshops in 14 penal institutions in Hungary and evaluated the risk behaviour and knowledge of prisoners. Most prisoners were aware of the dangers of AIDS, but to a lesser degree knew about prevention measures. Sexual exposure was the major source of HIV risk, as many worked as prostitutes or had partners who did so, and condoms were used seldom. Drug use and drug injection was not common (Gyarmathy et al., 2003).

Fliegauf (2010b) points out that there is especially among juveniles a lack of proper information on HIV and STD (Fliegauf, 2010b).

Testing for infectious diseases

Until 2003 screening for HIV (and TB) was compulsory in Hungarian prisons on admission. Since 2003, the screening is voluntary for prisoners (information is given by the doctor responsible for admission, information booklets are available in 17 languages), and anonymous tests may also be carried out (Reitox National Focal Point Hungary, 2006). Prior the change of regulation, the average number of HIV tests was more than 17,000. After the amendment this number significantly decreased. There were no additional positive test results found; eight HIV positive prison inmates are known. Only one of them was related to drug injection (Reitox National Focal Point Hungary, 2006: 50).

The following table shows the numbers of HIV screening in prison and the number and incidence of positive cases:

Table 18 HIV screening in Hungarian prisons

year	screened	positive	incidence
1988–1990	61,958		
1991	15,638	3	0,0191
1992	15,782	2	0,0126
1993	14,618	3	0,0205
1994	12,736	2	0,0157
1995	13,855	2	0,0144
1996	13,309	2	0,015
1997	14,635	3	0,0204
1998	14,776	2	0,0135
1999	15,273	6	0,0392
2000	14,862	3	0,0201
2001	15,936	7	0,0439
2002	15,537	3	0,0193
2003*	2,773	2	0,0722
2004	2,921	3	0,1027
2005	2,294	0	0
2006	943	0	0
2007	828	0	0
Total	248,674	43	0,0191

(Hungarian Prison Headquarter, 2008)

*not mandatory anymore

Counselling before and after testing depends on the person in charge, and is not in all prisons done according to the protocol, due to staff shortages (MacDonald, 2004). Prisoners tested positive for HIV were transferred to one prison (Tököl prison), where a specialized hospital is nearby, also when there was no medical need for this (CPT, 2006: 46).

Screening for Hepatitis C is unusual except for those prisoners who are blood donors. The Central Prison Hospital provides treatment for Hepatitis C (MacDonald, 2004). As there were no blood donors in 2006, no screening for

hepatitis C took place, but nine cases of HCV were diagnosed by symptoms (Reitox National Focal Point Hungary, 2007).

In 2007 there were 11,761 people screened for Tuberculosis (Hungarian Prison Headquarter, 2008).

Fliegauf states a lack of standardized questionnaires (like ASI) at admission to prisons, a lack of proper HCV screening and non-existing motivation programmes for inmates to undergo HIV screening (Fliegauf, 2010b).

OST

Opioid substitution treatment (OST) being rather new and not that common yet in the community, it is except for some rare cases non-existent inside prison walls. The first cases of methadone prescribing in Hungary were in 1987, but no protocols or legal background existed until 1998 (Gerevich et al., 2006). According to the law, OST is available in Hungarian prisons for those prisoners having been involved in methadone treatment before imprisonment. These prisoners start their imprisonment at the Institute of Forensic Monitoring and Mental Treatment and for the time of OST they are taken to an outpatient treatment centre. In 2005 there was only one person participating in MMT in prison, so the implementation of MMT is still extremely difficult (Reitox National Focal Point Hungary, 2006).

Other treatment

Drug using prisoners can participate in a drug treatment course in prison (since 1999) and by that reduce their sentence (MacDonald, 2004). The number of groups engaged in alternative psychosocial/peer counselling prevention programmes in prisons increased in 2005 (Reitox National Focal Point Hungary, 2006: 66f.). The numbers of prisoners in drug treatment are as following: In 2008 (January 1st – October 9th) 54 inmates participated in drug treatment, 18 of them had finished it already and two did not continue (Hungarian Prison Headquarter, 2008).

At the Forensic Observation and Psychiatric Institute in Hungary an ‘experientially-based treatment’ programme for prisoners is available. The treatment includes in-depth analysis of the drug user by a range of tests and group work. The professional team includes a psychiatrist (a drug specialist), a psychologist, a pedagogue and a social worker. In addition, a sociologist and a lawyer are also involved with the group. An advantage of this staffing is that they are not prison staff and therefore they could be more sympathetic with

the prisoners. The treatment duration is approximately six months but not all prisoners are in the prison for this long. If the prisoner is released prior to finishing the therapy, he has to complete it in the community (MacDonald, 2004).

Drug Prevention Units

In September 2003, the Prison Service Department started drug prevention units in four prisons, although legislation about them came later, and money to establish them was scarce. Twelve more drug prevention units were established in the following years, when financing by the National Drug Strategy was available.

The main characteristics of the drug prevention units, although no national standard exists, are mainly characterized by better living conditions (according to MacDonald, 2004):

- Prisoners are allowed more parcels and visits
- accommodation is better
- regular drug testing
- professional staff from the community
- reduced security level
- focus rather on prevention than harm reduction.

The study of MacDonald (2004) found prisoners satisfied with the drug prevention units, as they were not so much overcrowded, and generally the conditions were better than in the general prison. They were better prepared for release and treated in a more human way.

Criteria for admission on the drug prevention unit are that the prisoner has committed a crime due to drug use; was/is a drug user; or is in a dangerous situation for drug users where drugs are being used around him (MacDonald, 2004).

Harm reduction

Low-threshold services are implemented in the community (Reitox National Focal Point Hungary, 2006), like Needle and Syringe Exchange Programmes.

Harm reduction material was issued by the Prison Service Headquarter and distributed to the prisons, but only in Hungarian language. In some prisons regular talks on harm reduction issues are given by professionals from the community (MacDonald, 2003).

According to a 2004 research, condoms were available in Hungarian prisons but seldom in a confidential manner and not as a part of wider harm reduction interventions (MacDonald, 2004). Apart from the provision of condoms, no harm reduction measures are available in Hungarian prisons.

There are no needle and syringe programmes (NSPs) in prisons because of the missing legal background (Reitox National Focal Point Hungary, 2006), although in the community there exist needle exchange programmes (Bollini et al., 2002; MacDonald, 2004). Due to the low number of injecting drug users (IDU) in prison, the prison authorities did not envisage measures like needle exchange or provision of bleach in the late 1990s (Bollini et al., 2002). Bleach is also not provided in Hungarian prisons (MacDonald, 2004). Annual training for staff is provided on first aid and communicable diseases (MacDonald, 2003).

4.2.2 Results from field visits

Field visits included interviews with representatives of the (i) Ministry of Justice (prison administration), (ii) governor, social worker, nurse and focus group at the Budapest prison (men's prison) and (iii) Kalocsa (women's prison), governor, focus group and the head of social services. The field visit took place from 27 to 30 October 2008 and was supported by members of the NGO Váltó-sáv Alapítvány.

Compared to other EU-countries, drug use is not very widespread in the community and consequently in prisons. Although a slight increase can be noticed in Hungary in general and also in prisons, drug problems mostly centre around benzodiazepines, which are partly legally prescribed by psychiatrists and partly smuggled as contraband. This might indicate that the risk of abusing the prescribed medicines exists. Finally drug substitution substances (e.g. very strong tea called 'dobi') are widely used among inmates. The drug problem is still being considered as an issue of utmost importance.

4.2.2.1 Prison Administration

The National Prison Administration (NPA) began to develop measures against drug problems in prisons already in the first half of the 1990s. This reflected international experiences and foreseeable tendencies in Hungary. During this period preparatory measures have been taken in order to avoid drug problems in penal institutions as long as possible and to be able to prevent crises. Major elements of the preparation period were:

- familiarizing personnel with the problem in order to shape their attitudes
- organizing drug identification training for those in key positions
- training several specialists (educators, psychologists, doctors) to organize treatment programmes (UNICRI, UNDCP)
- participation of the expert of the Prison Administration in the Inter-departmental Committee for Drugs
- organizing courses for prison governors and respective heads of departments at Penal Institutions
- issuing a methodology guide to manage drug problems
- ordering research, publication of research results concerning drug-related risk groups in prisons
- implementing drug identification equipment capable of recognizing invented drugs.
- during periods of heightened security alert, drug detection dogs were regularly used in cooperation between Prison Administration and co-organizations.
- cooperation agreement with the Judicial Toxicology Institute
- system of detoxification was regulated and formed within the framework Emergency Medical Service.⁶

The help and support services for individuals and families affected by drugs are social work, medical care, and rehabilitation:

- The health care system of Prison Administration is capable of handling withdrawal symptoms and detoxification
- Drug addiction treatment basically in the central institution of the Budapest Prison.

The drug supply is being tackled by

- training of prison administration staff to identify drugs
- use of drug detection dogs
- control equipments for luggage installed in penal institutions to prevent illegal substances and equipment from entering the prison
- the Educational Institution of the Prison Administration and at the Prison Administration Department of the Police Academy, drug knowledge is part of the curriculum

6 Compare Dr. István Bökönyi (2001): Drug prevention strategy of the National Prison Administration Prison Administration Major

- several penal institutions, which have organized drug identification lectures, which are planned to be extended to national level. No central training exists until now which would refer to all the personnel.
- employees of Prison Administration have examined organizational and operational possibilities of drug free units in Austria and England
- institutions which have organized lectures on the topic, for which lecturers were hired from the police
- carrying out urine tests on inmates as an important issue but legal and financial conditions are not provided.

Demand reduction

Representatives of the National Prison Administration state that drug use is not really common in Hungarian prisons. Drug use is firstly concentrated on benzodiazepines (tranquillizers) and secondly on steroids, which makes prisoners more aggressive. There are no exact numbers of dependent prisoners available.

Provided legal conditions are met, urine tests should be done on 10% of inmates (randomly chosen) to be able to detect the spread of drug use.

The following measures of demand reduction are considered:

- the adaptation of ASI questionnaire is necessary to be continued
- initial drug screening tests are necessary in order to be able to deal with consuming and treatment needs
- after issuing the law, the development of drug prevention (drug free) units is required in 10 institutions, the operation of drug free units is required to be regulated
- sufficient amount of drug tests is required to be purchased.
- a progressive treatment system should be built up taking volunteerism and treatment possibilities into consideration.

All penal institutions should initiate contact with NGOs working in the area of drug prevention in order to develop possible ways of cooperation. Prevention programmes are ideally based on cooperation with external organizations. External organizations should also be charged with prevention and therapeutic procedures.

In order to obtain sufficient information, repeated representative examination is necessary to identify risk groups.

Educators, doctors and psychologists of penal institutions should be trained to be able to help and look after inmates with drug-related problems.

In Hungary there are some larger prisons (1,500–2,000 prisoners), which each have 2–3 doctors. In the women's prison visited one part time doctor is employed (see below).

With regard to vocational training a special event is being organised annually: a two day conference with prison doctors and health care workers. Main national guidelines are developed and adjusted during this meeting. Furthermore a clinical pathological meeting is being organised two times a year to discuss death cases etc.

Tokol prison hospital near Budapest is treating HIV-positive cases and is in many ways specialised on drug addiction and infectiology. Laszlax hospital is treating infectious diseases, has a special HIV unit, 4,000 HIV/HBV/HCV cases, 82 PCR+ HCV treatment, 190 treatment places for drug users: two hours service all 2 weeks for six months.

Recent research in Hungarian prisons (Budapest Prison survey) revealed that drug use before imprisonment has been stated by 58% of the respondents, daily use of benzodiazepines before by 29% and IVU before by 33%. Other related problems were

- gang identity,
- opioid vs benzodiazepine exchange
- 'travelling' (VáltóSáv, Csáki-Márton-Meszáros 2009)⁷.

Drug services

In Hungarian prisons drug services are divided into several levels:

a.) Therapy by group meetings and prevention measures (3 levels)

1. Budapest (only): detainees are screened at the entrance, based on this it is decided by psychiatrists and psychologists which level is suitable for them. The therapy offered consists of group meetings. After six months participants get a certificate and are being released. Prisoners also apply from other prisons to get there. For severe cases of addiction the Psychiatric Institute is responsible. Within the group meetings life events are put in the focus, films,

⁷ Presented by Fliegau, G. (2010a). Drug related facts, challenges and needs in the Hungarian Prison System. 2nd Connections Conference, London.

role games, sometimes harm reduction measures, sometimes drug free oriented topics are discussed. Additionally psycho-therapy is possible. Motivation is needed, everyone has an individual aim. The population of Roma is over-represented.

2. For less ‘serious’ cases of drug use (11–12 institutions) a meeting once in a fortnight is offered. Apart from lower frequency of meetings, no clear distinction between the above mentioned service and the second option seems to exist.

3. Prevention activities are carried out in every prison. At this stage NGOs are involved in developing a curriculum (which has to be approved by the psychiatrist). There is a very low level of involvement in drug use (e.g. Cannabis). The main difference on this 3rd level compared to the previous ones is prevention instead of correction.

Experts diagnose on the court, if someone is an addict or not, but according to the interviewees in the prison this may be seen as a ‘biased’ diagnosis.

There is a National Drug Prevention Strategy in place.

b.) Drug free units (DFU)

The second key approach in Hungarian drug service infrastructure in prisons are drug free units (DFU), working mainly with privileges (sports, equipment is the essential way). The participation in DFUs is voluntary. It includes participation in an urine testing programme. 350 prisoners currently participate in DFUs in 23 prisons. Any prisoner can apply for participation in a DFU – based on support of prison workers.

The development of DFUs can be described as follows:

- 2003: 11 prisons offered DFU (only in prisons for sentenced prisoners)
- 2008: 30 prisons offered DFU in total with approx. 350 prisoners.

Now DFUs have also been installed in pre-trial prisons (6-bed-cell). Usually one urine test is carried out randomly per month, mostly tranquilizers are found. The pre-requisite is to sign a paper to agree on the programme. If the urine test is positive the police is being informed. According to the interviewees heroin has never been found in the urine tests.

The explanation for the increase of DFUs is that there is a demand expressed by prisoners: the application for drug free unit makes a positive picture when it comes to release, and it is an increase of life conditions:

For DFUs the respective prison administration receives additional funding for organisation, equipment, dogs etc. NGOs are involved in the work of with the DFU programmes.

The benefits for prisoners of housing in a DFU are quite clear: more visits, refrigerator, TV – Set, but not more parcels (only one parcel a month etc., contingency management). Thus the living conditions are much better in the DFUs than elsewhere. Finally the AA is in the prison once a week.

According to the interviewees there seems to be no envy from other prisoners, because a special committee based on psychological expertise is placing people living ‘at risk’.

Opioid Substitution Therapy (OST)

The start of OST is planned in 2009 with Suboxone[®] for prisoners in the last 2–3 months before release (‘retoxification’), for continuation in the community. Suboxone[®] has been chosen because of its safety profile. Another reason for choosing Suboxone[®] is that it is freely available from the pharmaceutical industry for the first ten patients although it is difficult to control because of the sublingual intake and secondly because of the interaction with benzodiazepines.

The Forensic Psychiatric Institute is planning the implementation of the OST treatment. Still there are conflicting views about the necessity to introduce OST. According to some interviewees an assessment is needed first. In 2008 only seven prisoners and in 2009 approx. nine prisoners were eligible for OST.

There was no OST in Hungarian prisons at the time of the visit. The National Prison Administration (NPA) is not certain, whether it is really needed, because opioid use in Hungary is quite specific, a pattern of mixed drug use is common, cannabis, tranquilizers and speed are the most widespread drugs among prisoners. There is very few opiate use in prison according to official figures, thus very few opioid addicts.

In the community there are five addiction centres, where Suboxone[®] is prescribed. The problem is that in order to continue OST after release the patients have to pay for Suboxone[®] themselves. It is quite likely that they will not buy Suboxone[®], but other drugs instead – although methadone is free in the community as well. There are no data about the number of prisoners being in methadone treatment before incarceration.

Also interviewees indicated that harm reduction measures have to be weighed as there is very little opiate consumption inside.

According to the doctor in the Budapest prison no serious detoxification problems for IDUs are experienced. Symptomatic treatment might have happened elsewhere in pre-trial for instance. Methadone treatment is being stopped once patients enter the prison. According to representatives of the National Prison Administration there are no complaints about the non-existence of OST.

Benzodiazepines are prescribed constantly and continuously. These medications have a long history in Hungarian prisons and outside (starting in 1978; were introduced later). Rivotril® is the most commonly used benzodiazepine (Valium like).

4.2.2.2 Budapest prison

Budapest prison has 1,018 places for prisoners but held a total of 1,506 at the time of the visit in October 2008, both sentenced and pre-trial, predominantly men and a few women. At that time there were four doctors employed.

Complaints of the prisoners were mostly on issues regarding accommodation and health problems, which were:

- no access to the ‘right’ medicine/medication
- only few different medicines are available
- no satisfaction with the treatment.

In opposition to the views expressed by prisoners, representatives of the National Prison Administration perceive the level of health care as sometimes even better than outside prisons.

The health care is in the responsibility of the Ministry of Justice (Prison Administration). The European Prison Rules (2006) serve the doctors and governors as guiding instrument; equivalence of health care is seen as an important issue.

The pre-trial section is working with contracted doctors from the community, but there are 24h nurses, in case of emergencies. These patients can be transferred to the local hospital. The prison hospital is situated in Tokol (30km from Budapest), specialised on mental problems. Szeged is a specialised institution for the needs of prisoners with long term health problems.

Data given to us during the visit say that approx. 10% of the prisoners (approx. 1,500 prisoners) were using drugs before imprisonment, 190 are treated in prison. Drug finds are mostly confined to THC, injecting equipment has not been confiscated in the last years before the visit. Strong tea has a long tradition among prisoners in Hungarian prisons.

Before 2003 obligatory HIV testing has been carried out, since then it became a voluntary offer. Tokol prison is a specialised unit to treat HIV-positive prisoners (there are living eight to nine HIV-positive prisoners at the time of the visit). In general the HIV rates in Hungary are much lower than in most of the other countries in Europe.

The National Prison Administration worked out a guideline for hepatitis testing, based on the work in the community. According to the interviewees of the health unit, language problems among prisoners or in the communication between guards and prisoners do not exist.

Drug using prisoners can be taken into a psychological treatment programme for a one year treatment. When participating in this treatment programme the charge is being dropped.

The implementation and operating of drug free units (DFU) is the key approach in Hungarian drug service policy and practice. The concept of DFUs is based on a voluntary participation of prisoners, which obliges them to take part in a urine testing programme. At the time of the visit there were 350 places, from which 270 places were occupied in 23 prisons.

Interview with the prison doctor

There are five doctors working for 1,100–1,200 prisoners, paid and formally employed by National Prison Administration.

According to the interviews the major health problems of prisoners in this prison are:

- personality disorders/problems after spending many times in prisons
- heart diseases, vein problems
- skeleton problems
- digestion problems.

According to the interviewees suicide attempts are often carried out to get benzodiazepines prescribed. This happens occasionally (approx. 50 attempts

per year), mostly for manipulation purposes. In the last four years no successful suicide attempt in Budapest prison occurred.

According to the interviewees sexual activity or sexual risk behaviour happens in very few cases, it is not a medical problem. There are almost no tattoos or piercing. HIV testing is voluntary. ARV is given in all cases where patients need this.

200 prisoners have been tested for BBV: 15% were HCV-positive, no single HIV-positive case has been found according to this recent study. A compulsory TB-test is performed once a year in Tokol – there are no refusals of TB test.

There are no special strategies for prisons on (i) drugs, (ii) infectious diseases, (iii) or harm reduction measures. There do exist several cooperation with specialised doctors on problems like skeleton, rheumatism, physio-therapy, eyes etc.

According to the interview partner more doctors are needed, but there were times when there were even less (e.g. one doctor for the whole institution). Now there are 1,200 prisoners, but there were times when there were 2–2,600 prisoners and also only five doctors. The prison doctors give out drug prescriptions (especially benzodiazepines) based on psychiatric advices, also for a long periods (1–1.5 years). The allowance to introduce benzodiazepine prescription can be given by the psychiatrists (only), they take the decision and the prison doctors prescribe and see the patients on a daily basis. The cooperation between doctors and psychiatrists is described as being not perfect. There are not enough psychiatrists at the moment. This year two overdoses with benzodiazepines occurred.

Focus Group

According to the participants in this focus group (included five persons) drugs are also available in this prison. Some in the group said that everything is available like in the community. It's just a matter of money.

Certainly also injecting occurs, but only rarely. Insofar needle sharing happens also only rarely. Benzodiazepines (Rivotril®) are the most widespread drugs. Cannabis and heroin are also used very rarely.

According to the focus group members no sex for money is happening in the prison.

Tattoos are similarly widespread as in the community, it is a fashion like outside, although it is forbidden, but not searched for inside. Piercings are not very widespread among prisoners.

Prisoners feel well informed about BBVs, TB and STIs, well informed by their own life experiences.

Regarding OST in prisons there was a majority of prisoners in favour of an introduction, especially for detoxification purposes. At the moment drug addicted opiate users experience severe withdrawal symptoms in the institution. Currently no OST is offered in prisons, although some prisoners would need OST.

Complaints are expressed about the services in the psychiatric hospital. For many prisoners treated there it is not clear what kind of injections with which contents they get in the psychiatric institution. No proper information is being delivered to the prisoners.

Commonly prisoners in the focus group express their wish for more extra visits. Prisoners feel not sufficiently prepared for release. Although they intend to abstain from drugs many of them lose control very quickly after release.

4.2.2.3 Kalocsa – female institution

Kalocsa is a women's prison with 240 places and 282 inmates at the time of the visit in October 2008. It is one out of three institutions for women in Hungary.

There is only one high security prison for women: it holds 282 women in an old court house with 73 cells in total, with up to five women in a cell, sometimes even ten. Overcrowding is being perceived as a major problem.

According to the governor drugs are not a very big problem. Drug related offences are mainly committed by drug traffickers, more than by drug users. If at all, drug problems only occur during the beginning of the sentence. Alcohol is perceived as a far bigger problem; also therapeutic drugs are a problem (like benzodiazepines). Special help groups for alcoholics are being organised. Smuggling of alcohol is very rare. Those women who work outside are very proud of their privileged job and rarely would misuse this job for smuggle purposes.

The structure of the prisoner population is quite homogenous, at the time of the visit there were only six people coming from other countries (four Russians, one each from Slovakia and Ukraine).

The Medical Unit consists of one doctor, available every day (doctor for general medicine), two times per week a women's doctor is coming in one time per week a dentist and a psychiatrist. Also a psychologist is offering services.

The prison administration maintains many co-operations with several NGOs – mainly through nine educators in the institution with:

- family help
- drug services – application for work
- groups with juveniles
- re-socialisation help
- help for ex-prisoners

The prison doctor is working one time per week in the community hospital, which facilitates relationships with the community hospital.

Regarding drugs only cannabis has been seized (only one time) in the last two years.

Interview with the prison doctor

Apart from the doctor six nurses are working in the prison. According to the interviewee the access to the medical service is easy: the doctor can be approached by all women. Medications are given out three times a week.

The major health problems perceived in the daily practice are:

- head aches
- stomach aches
- sleeping disturbances

Self harm phenomena occur occasionally, but rarely. Also sexual relationships are occurring rarely; they do not form a medical problem. Approx. 90% of the detainees are tattooed, but not done in prisons.

Approx. 85% of the patients are HCV tested, eight prisoners are found to be HCV-positive according to a recent study (seven of them were former IDUs). No HIV-positive cases were found. HIV testing is voluntary. Education about the test is done during the basic examination after entrance (orally and in written form the patients are informed). Only very few women are applying

for a HIV-test. A very close cooperation does exist with the local hospital; also surgery is possible.

3–6 months prescription of Rivotril® exists, the Forensic and Observation Psychiatric Institute (IMEI) prescribes also for longer periods, given on a DOT basis by nurses who supervise the intake. According to the psychologist benzodiazepines are more used among men, although women have more stress. No or very little black market for these medications does exist.

Focus Group

According to the participants of the focus group (five female prisoners in a DFU), psychological services are always accessible. Every week a doctor and a psychiatrist are coming in. No tattoos or piercing are being done in the prison. The participants have privileged equipment in their DFU cells (like TV and fridge).

Also they have the right to receive more parcels in the DFU:

- Normally: 1 x 2 pieces per month
- DFU: 2 x 2 pieces per month
- Normally: 2 x 5 kg per month
- DFU: 3 x 5 kg per month.

Also the doors between the cells are kept open. The DFU is supposed to be an important part of the pre-release training. Two years before release the prisoners can apply for being transferred to this DFU.

Interview with a representative of a NGO

NGOs maintain only very few connections with the prison administration; it is perceived as being no real cooperation, as it is not a continuous working relationship and more dependent on external funding (like EU projects).

Prisons decide themselves with which NGOs they are cooperating with. The NGO is working in 8–10 prisons, this changes always due also to national and European applications. Mostly only two NGOs receive funding and support. European projects get co-financing from the NPA. Schooling programmes, social reintegration, peer support programmes are also supported.

A lot of time is being spent on organising accommodation for prisoners after release. Probation Service is part of the Prison Service, and there is no social welfare programme for just released prisoners in Hungary.

4.2.3 Results from inmates' Survey

In Hungary the survey was conducted in four prisons (for details see chapter 2.5).

4.2.3.1 Sample

In Hungary 102 inmates answered the questionnaire. They divide almost equally onto the four prisons:

- Budapest Prison (26.5%),
- Kalocsa prison (24.5%),
- Marianosztra (19.6%), and
- Balassagyarmat (29.4%).

A quarter of the sample is female (24.5%). The mean age of the sample (N=91) is 33.5 years (SD 10.2), the median is at 30 years. The range in age is between 20–67 years. The age difference between men and women is statistically significant ($p=0.000$). Men are with 30.2 years (SD 8.5) younger than the women with 45.0 years (SD 9.3) on average.

The vast majority of the interviewees (N= 101) speaks Hungarian as their mother tongue (94.1%). The remaining state Ukrainian and Lithuanian (1% each) as mother tongue and 2.8% others.

Table 19 Education level, Hungary (% , N=100)

	total	men	women
no formal education	6.0	6.7	4.0
Primary school	24.0	25.3	20.0
High school	48.0	49.3	44.0
specialized school/college	5.0	6.7	0
University	6.0	5.3	8.0
other	11.0	6.7	24.0

Other education mentioned includes trainings/apprenticeships as industrial school, dressmaker, cook.

There are huge gender differences concerning the marital status (see table 20), which are statistically significant ($p<0.000$). Half of the men does have a partner, another third is single and only 12% are married. On the other hand the women are more often married or divorced, almost a third for each,

and also five of them are widowed. Therefore women are (or have been) far more often in official partnerships while men usually are not. This difference may partly be explained with the age of men being on average 15 years younger than the women.

Table 20 Marital status, Hungary (%)

	total	men	women
single	26.0	30.7	12.0
married	17.0	12.0	32.0
having a partner	38.0	48.0	8.0
divorced	14.0	9.3	28.0
widowed	4.0	0	20.0

65.3% of the sample does have children (N=95). Of the men only 57.7% do have children, while almost all women (87.5%) do have children (p=0.008). The number of children ranges between 1 and 5, the mean number is 2.2 (SD 1.2), 2.1 (SD 1.2) for the men and 2.4 (SD 1.3) children for the women.

4.2.3.2 Imprisonment

The majority of inmates is sentenced to rather long sentences of more than three years, as can be seen in figure 15. Remarkable is that the women got longer sentences than the men, the vast majority of them for more than three years and none less than a year. Most men also serve a sentence of more than three years but a quarter of them got a sentence between 1 and 3 years and a few even less than that.

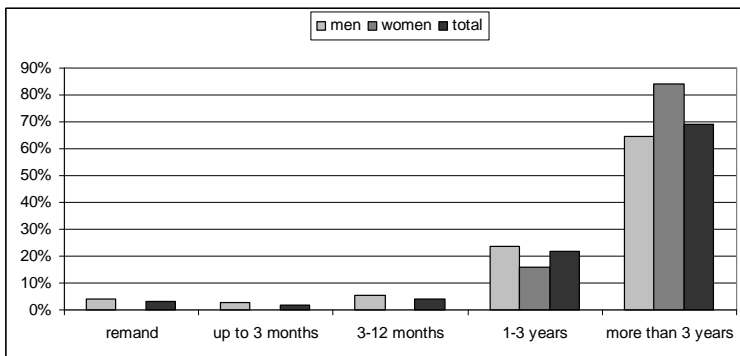


Fig. 15 Length of current prison sentence, Hungary (N=101, in%)

Most interviewees have been imprisoned for more than a year already before the time of the survey and more than a third already more than three years.

Table 21 Stay in prison on this sentence until now, Hungary (N=99)

	total	men	women
3 months or less	9.1	9.5	8.0
3–12 months	9.1	12.2	0
1–3 years	44.4	44.6	44.0
more than 3 years	36.3	33.8	48.0

Prison experience is extensive for both men and women. Looking at the time the sample has spent in prison during the last ten years, more than half of the sample spent more than three years in prison, without any differences between men and women. The majority (59.3%) of both men and women has spent more than three years in prison during the last ten years before the survey, only 6.6% have been less than a year in prison during those ten years. The interviewees report high numbers of different prison stays (N=87) with a mean of 22.6 (SD 26.7) times in the last ten years, men 24.1 (SD 27.6), women report 18.0 (SD 23.8) different imprisonments. The median lies at 9 different prison stays, ranging from 0 to 84 times, mainly due to this high number of 84.

When living in prison, some situations cause difficulties and suffering for the inmates. The inmates of this survey reported most often the separation from the partner as difficult, as well as the separation from the children and the prison restrictions generally (see figure 16). The only differences between men and women concern the separation from the partner and boredom, both items women do report significantly less than the men. Problems with drug or alcohol don't play a role.

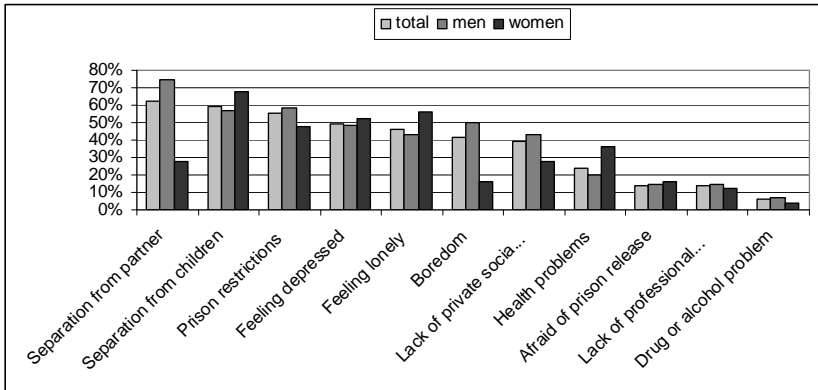


Fig. 16 Suffering in prison situation, Hungary (N=99, in%)

4.2.3.3 Health

The health status is rated mostly as rather good (see figure 17). All over the physical health is rated better than the mental health. The women rate their physical health worse than the men, with a quarter of them as bad or very bad, while for the men it's 10.9%. For the mental health this difference doesn't occur.

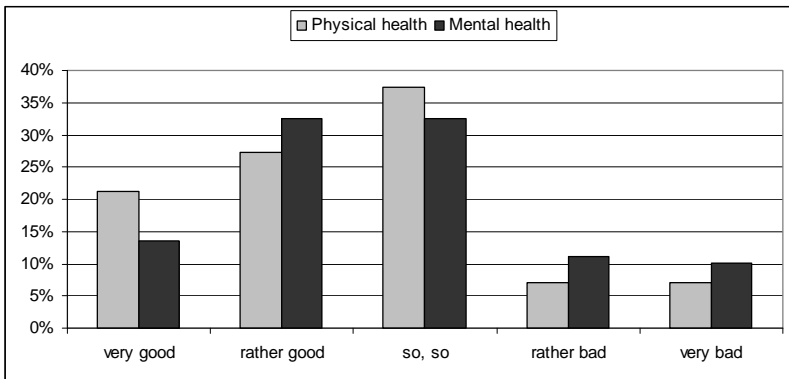


Fig. 17 Rating of own health status, Hungary (%)

Infectious diseases like HIV and Hepatitis C (HCV) only play a minor role among the Hungarian inmates (see table 22). One inmate reports to be HIV infected. Response rates are rather high among the men, while almost a quarter of the women do not want to answer the question for HIV and also hepatitis infection or tuberculosis status. This difference between men and women is statistically significant ($p < 0.005$).

Only one male respondent confirms to be HIV infected (1.1% of the sample), while 22.7% of the women did not want to answer their status of infection. As well as for HIV the infection rates with hepatitis B and C are low among the sample. Nobody reports a hepatitis B infection and only one male inmate reports a HCV infection, the same reports the HIV infection. Tuberculosis (TB) is reported by nobody of the sample (N=84), almost 10% are not answering this question. The rate of people not knowing about their TB status is low with 3.6%. The one inmate with HIV and HCV infection is not in anti-retroviral nor antiviral treatment.

There are further health problems reported by the sample (see table 22). Almost half of the sample states to have no health problems. Differences between men and women are not significant, although the women tend to report more often symptoms (except for depression where more men report this).

Table 22 Other diseases in the last 30 days, Hungary (%)

	total	men	women
Sleep disturbances (N=91)	47.3	46.3	50.0
Depression (N=91)	24.2	26.9	16.7
Respiratory problems (N=92)	16.3	14.9	20.0
Epileptic fits (N=91)	3.3	3.0	4.2
Hepatitis A (N=91)	3.3	1.5	8.3
Sexually transmitted infections (N=91)	1.1	1.5	0
other (N=90)	4.4	4.5	4.2
<hr/>			
no health or psychological problems (N=90)	48.9	51.5	41.7

Other health problems that were reported include: combustion, rheumatism, and schizophrenia.

4.2.3.4 Drug use

When asked to estimate the percentage of substance users in prisons, the answers varied considerably, ranging often from 0–100% for each substance. About half the sample stated not to know the percentages so the number of those actually giving estimations was low. Apart from alcohol and cannabis it's mainly benzodiazepines, amphetamines and substitution medication with relatively high estimations of use.

Table 23 Estimations on drug use in prison, Hungary

	Mean / Median Percentage	Range Percentage	Don't know (% of all)
Cannabis (N=27)	23.7 / 10	1–100	48%
Alcohol (N=18)	21.5 / 7.5	0–100	52%
Heroin/Opiates (N=17)	10.3 / 5	0–60	52.9%
Kompot (N=10)	11.6 / 3	0–40	56.9%
Cocaine (N=17)	16.1 / 5	0–100	52%
Crack/freebase (N=9)	5.7 / 0	0–40	58.8%
Amphetamines (N=18)	24.6 / 15	0–80	52.9%
Methadone/buprenorphine (N=13)	28.6 / 20	0–80	53.9%
Benzodiazepines (39)	60.7 / 60	0–100	43.1%
Ecstasy (N=16)	18.8 / 12.5	0–70	52.9%

Although the answers on the own substance use in prison were not given by everybody, the percentages are analyzed for the whole sample, the numbers on the use therefore giving the percentage of the whole sample (see figure 18). Apart from tobacco the highest lifetime prevalence is reported for cannabis, alcohol, and cocaine, then followed by ecstasy and amphetamines. Generally the experience with drug use is not high.

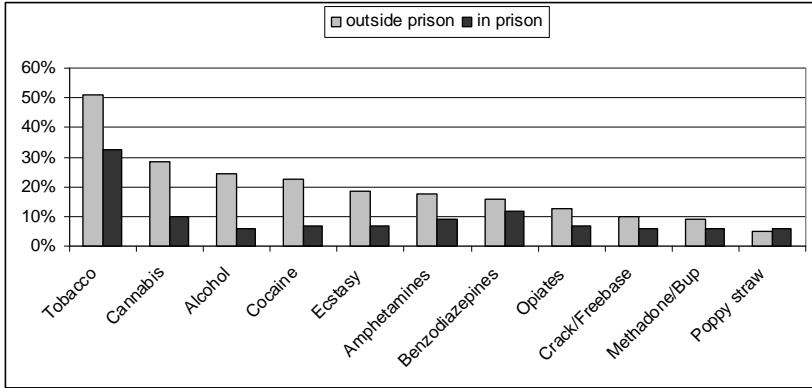


Fig. 18 Drug use prevalence inside and outside prison, Hungary

In prison the prevalence of drug use is very low, among the women only single ones do use illegal substances at all, four of them report benzodiazepine use, and only one cannabis and amphetamines. For men the life time prevalence in prison is a little higher. Similarly the life time prevalence outside prison is higher among the men than the women. The only exception here is benzodiazepines, where women report more often a use, both inside and outside prison than the men.

There are hardly any answers on the issue of route of administration, therefore this question can't be analysed. The acquisition of drugs in prison is perceived mainly as difficult by 71.6% of the sample (see figure 19). The women in the sample rate it even more difficult with 81.9% saying it's rather difficult or very difficult compared to 69.8% of the men. This may be due to the little demand of the sample, as many of them do not use drugs in the community either.

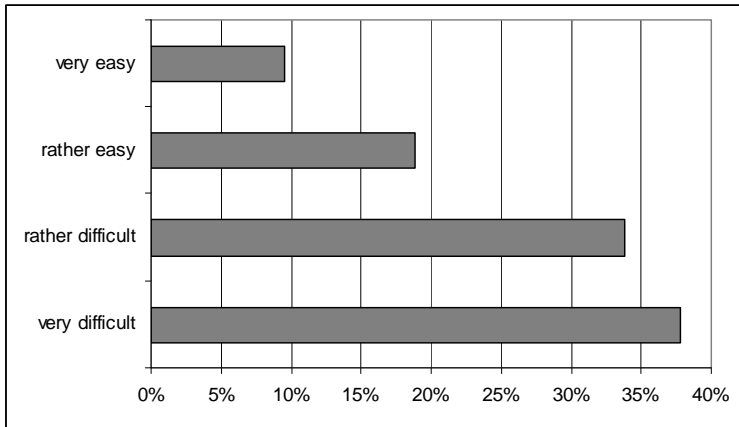


Fig. 19 Acquisition of drugs in prison, Hungary

4.2.3.5 Risk behaviour

The vast majority of the sample (90.5% of n=63) does not inject drugs. Therefore the multiple use of syringes is reported only by three persons. Only one person each reports syringe or equipment sharing often, every now and then or seldom, as the majority of the sample is not injecting, neither in the community nor in prison.

Almost half the sample confirms the existence of sexual violence in prison, more men than women (see figure 20). Physical and psychological violence is reported by even more of the respondents, and again more men report violent behaviour than the women. For all questions a substantial part of the inmates stated not to know about it, especially with sexual violence more than a third stating this.

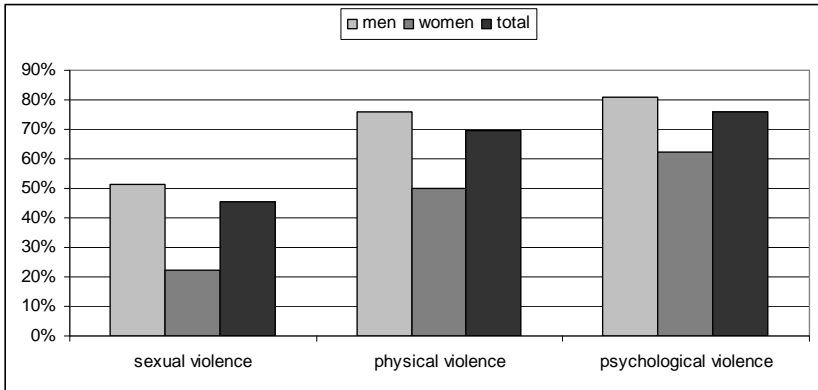


Fig. 20 Estimation on violence, Hungary (%)

Again for estimations on the different forms of sexual contacts only a minority of inmates answered these delicate questions. Therefore the answers have to be looked at cautiously. The mean estimation on prisoners having sex in prison (N=41) is at 34.7% (range 2 – 100%), for paying for having sex (N=23) the mean estimation is 25.7% (range 0 – 100%), and for sex against somebody’s will (N=32) it is at 22.9% (range 0.5 – 100%). Other risk behaviour is reported by only a small part of the sample, as can be seen in figure 21. Only tattooing is reported by a quarter of the sample, men report tattooing significantly more often than the women (p=0.003).

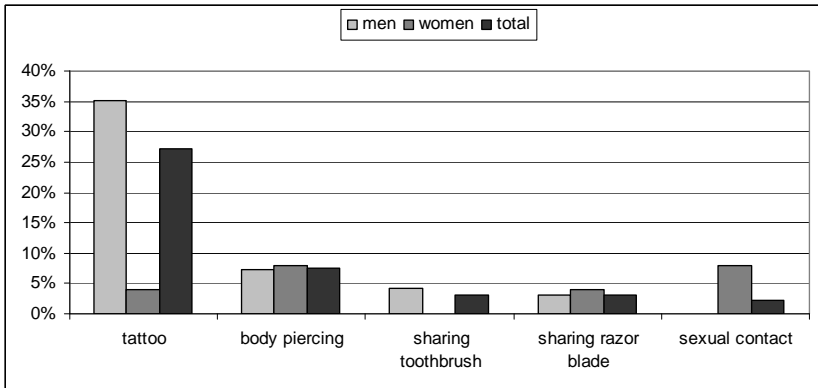


Fig. 21 Risk behaviour, Hungary (%)

4.2.3.6 Help Services

As the majority of the Hungarian sample is non drug users, they utilize the drug help services only to a small degree. Therefore it might also be that they don't understand all the different kinds of support possibilities. The most frequently requested services were health education training (49.4%, only 17.2% said it's available) and individual counselling (40.2%, with 12.6% saying it's available). Only a minority (between 3 and 17 inmates for each service) answered the question on their service use in the community, therefore this question can't be evaluated.

Further remarks on which other services in prison they find important can be divided into two groups: General needs concerning the prison restrictions, and those needs about health care. Requests concerning the health care system are only few, the majority affects the prison system in general.

Table 24 Suggestions on services, Hungary

Prison system	Health care
Education and learning possibilities (5x)	better medical care
preparation for release (3x)	drug prevention
more cultural programmes, group activities (2x)	healthy and natural food
Sport, better gym (2x)	learn more about diseases
warm water in all bath every day (2x)	medicines from civil life
anabolic steroids	psychiatrist
better jobs	providing support
bigger rooms	providing higher level of health care
control prison administration	
conversation to civil people	
Computer, CD-player	
keep the financial account of prisoner	
more open correspondence	
private/intimate visiting hours	
separated rooms for religious people	
speaking to probation officers	
use of mobile phone	
visiting hours for more persons	

Only a minority of the inmates have a treatment plan (9.7%) or transitional care plan (9.5%), while assistance for prison release seems to be offered in more cases (30.7%). No major differences occur except that no women states to have a treatment plan, in contrast six of the men do.

The quality of prison treatment is assessed as predominantly bad, as can be seen in figure 22. But women do rate the quality of treatment much better than the men, which is statistically significant ($p < 0.000$).

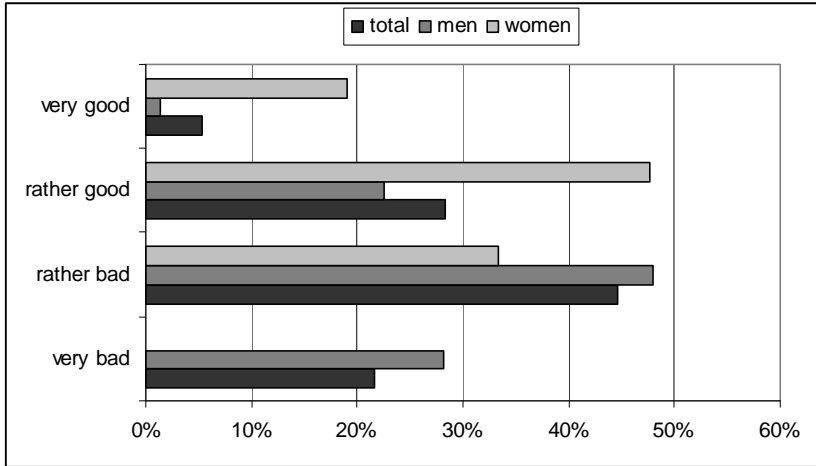


Fig. 22 Assessment of the quality of health care, Hungary (N=92, %)

4.2.4 Results from the presentation of the results in Hungary

The presentation of the study results took place on 18th of June 2010. The following participants attended the meeting:

Colonel Dr. Banu Zsoltné Judit Szabó, dr	Ministry of Interior, Deputy Under-secretary of State for Policy and Coordination
Brigadier general Katalin Heylmann, head of major department, chief advisor	Hungarian Prison Service Headquarters, Department of Health
Captain Szilvia Kőszegi	Hungarian Prison Service Headquarters, Department of Detention Affairs
Major Mihály Kovács head of department	Balassagyarmat Strict and Medium Regime Prison, Department of Implementation

Szilágyi Erika	Budapest Strict and Medium Regime Prison
Lieutenant colonel Eszter Tímea Tanács, dr. acting governor	Kalocsa Strict and Medium Regime Prison
Takács István Gábor	Hungarian Civil Liberties Union, Drug Prevention Foundation
Csáki Anikó, finance manager, secretary of the board	Change Lanes Foundation
Kincses Tamás András, teacher	Change Lanes Foundation
Németh Dóra, psychologist	Change Lanes Foundation
Papp Mónika, social worker	Change Lanes Foundation

The results of the quantitative study have been presented by a slide – based lecture and then discussed.

It has been emphasised that the study results were in line with the everyday experiences of prison governor, prison administration, staff and NGO represented in the this meeting. Participants made clear that the treatment and health care delivery in prison should be and largely is of the same quality and should be in the same way accessible like outside. Some voices said that health care delivery in Hungarian prison is even better than outside. An indicator for this statement was that the prisoners don't need to pay for medications and treatment. Furthermore a 24 hours health care via emergencies is provided.

Also the data found on injecting drug use and BBVs are in line with results of a joined voluntary HCV screening programme with drug injecting imprisoned persons (N=1,166) carried out by the Hungarian National Focal Point (HUNFP 2009) in June 2008. 12.7% of the respondents had ever injected drugs. In the entire sample there were 30 persons (2%), whose serological tests indicated HCV positivity, 21 of them had already used drugs in their lives, and 17 persons had injected drugs. There were no HCV infected persons among those who reported injecting drug use while staying at the facility.

This is in line with screening data of 2007 and 2008. In these two years a total number of 4,782 persons were screened in detention facilities. 176 persons (3.6%) tested positive for HCV antibodies (EMCDDA 2010: 71).

All the participants agreed in their perception of the drug problem in Hungarian prisons. While the degree of use of illegal drugs remains quite low, the use of benzodiazepines like Rivotril[®] is very widespread. No solutions, apart

from attempts to increase the security situation (with sniffer dogs, and better qualification of staff to identify drugs), are in sight. It is seen as a problem of the psychiatrists prescribing this medication, which only they are allowed to do in their therapeutic freedom. From Kalocsa prison it has been reported that the medical unit gave out Ritrovil[®] only in powder form, as a second step they gave it out only under supervision (DOT). Some women then started to sell chalk, which they scratched from the walls and declared it as Ritrovil[®]. In other cases the medication has been vomited after the intake.

With regard to opioid substitution treatment (OST) it was said that as soon as it is requested to a higher degree by prisoners, it would be made available in prisons, too. At the moment there were only requests from two prisoners to get Suboxone[®] six months before release.

Still overcrowding was perceived as the major problem affecting also prison health care delivery. No solution was in sight for this problem, overcrowding might even increase within the next years. The situation even exacerbates by the lack of good qualified prison staff due to financial restrictions. Unanimously it was said that the qualification of staff is a key approach in detecting drugs (in parcels etc.) and also in health care training.

In Tokol a new specialised unit is being opened with regard to psycho-social care.

4.2.5 *Conclusions*

A low and further decreasing prison population rate of 149 prisoners per 100,000 inhabitants is characterizing the prison situation in Hungary. This is much less than in other Eastern European countries. However, it exceeds the European average.

The epidemiological situation regarding the prevalence of addiction from illicit drugs and BBV infections is regarded by most respondents and responsible persons from the Ministry of Justice respectively Prison Department as not as alarming as in other East European countries. Indeed, few indicators were found with regard to injecting drug use and related infectious diseases (12.7% of prisoners showed lifetime prevalence of injecting drugs: 2% HCV seropositivity, and a very low prevalence of HIV). However, risk behaviour does not only comprise injecting drug use, but also unprotected sexual activities and piercing/tattooing among prisoners. This risk behaviour was also reported by Hungarian prisoners and need further observation and offers of prevention and risk reduction.

While the degree of use of illicit drugs remains considerably low, the licit and illicit use of benzodiazepines like Rivotril® is very widespread among prisoners. Psychiatrists obviously are prescribing benzodiazepines for long periods of time. Apart from the legal prescription, and probably also connected to that, there is a huge market of and demand for benzodiazepines in Hungarian prisons. Some promising strategies to control the intake of Ritrovil® have been applied (Medical unit of Kalocsa prison is handing it out only in powder form, if this doesn't work it is given out only under supervision (DOT). However, this absorbs a lot of staff resources.

The Hungarian specialities are the drug prevention units in prisons, which build a frame and infrastructure for issuing hot topics and risk reduction messages.

The health status is rated by prisoners mostly either as rather good or even very good. The majority rates its health status "so so". All over the physical health is rated better than the mental health. Prisoners are more suffering from the separation from the partners, as well as the separation from the children and the prison restrictions generally. In this respect overcrowding plays an important role and it was perceived as the major problem affecting also prison health care delivery. Overcrowding might even increase within the next years. Generally the situation exacerbates by the lack of good qualified prison staff due to financial restrictions.

According to this study violence is a big issue in Hungarian prisons. Almost half the sample confirms the existence of sexual violence in prison, physical and psychological violence is reported by more than two thirds. This could be understood as connected to overcrowding on the one hand and the consumption of steroids on the other hand.

The treatment and health care delivery in prisons is largely perceived by professionals as of the same quality and should be in the same way accessible like outside. Some voices said that health care delivery in Hungarian prison is even better than outside. Indicator for that was that the prisoners don't need to pay for medications and treatment. Furthermore a 24h health care via emergencies is provided. However, prisoners complained mostly about accommodation and health problems, which were inaccessibility of their 'right' medicine/medication, dissatisfaction with treatment and availability of only few different medicines. Complains also were expressed about the services in the psychiatric hospital. For many prisoners treated there transparency is

lacking about the kind of injections with which contents they get in the psychiatric institution. No proper information is being received by prisoners.

Regarding OST in prisons there was a majority of prisoners in favour of an introduction, especially for detoxification purposes. At the moment drug addicted opiate users experience severe withdrawal symptoms in the institution. Currently no OST is offered in prisons, although some prisoners would need OST.

4.3 Lithuania

4.3.1 General information on the prison system

There are 15 penal institutions in Lithuania; three remand prisons, nine institutions for adult sentenced men, one for adult sentenced women, one for juveniles both remand and sentenced, and one prison hospital. In 2000 the responsibility for the prison system was referred from the Ministry of Interior to the Ministry of Justice (Semenaitė, 2009).

4.3.1.1 Prison statistical data

In Lithuania 8,655 inmates were in penal institutions on January first 2010 (Walmsley, 2010a), for a development since 1992 see figure 23. In the beginning of 2009 there were 8,000 prisoners incarcerated (Semenaitė, 2009). The occupancy level (prisoners per 100 places) in 2008 is with 86.8 low in the European comparison (Walmsley, 2009).

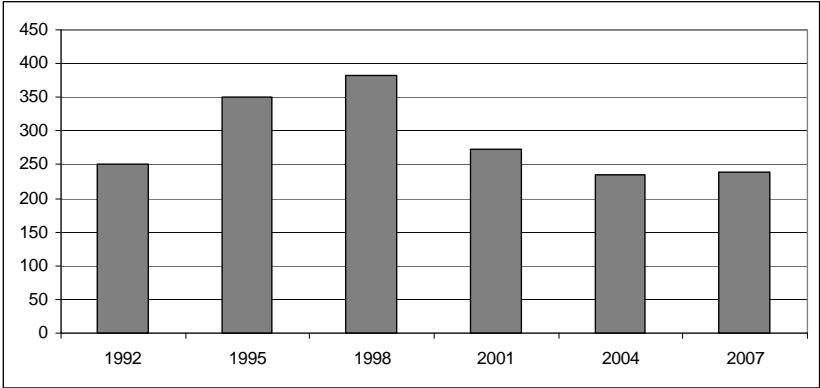


Fig. 23 Incarceration rate Lithuania (per 100,000 inhabitants)

The mean age of Lithuanian prisoners is 32.7 years. The percentage of juvenile prisoners (under the age of 18) was 2.4% in 2008 (Walmsley, 2009), another 8.3 are between 18 and under 21 of age in 2006 (Council of Europe, 2007). The percentage of female prisoners was 4.4% in 2008 (Walmsley, 2009), this is slightly increasing since 2006 with 3.8% (Council of Europe, 2007). In Panevezys prison 181 convicted women live with their children (Stankuviene, 2009). The number of foreign prisoners is 0.9% (Walmsley, 2009), of the 1% foreign prisoners in 2006 41% were pre-trial detainees (Council of Europe, 2007).

The length of the prison sentences is rather long with almost half the inmates serving 3–10 years (see table 25).

Table 25 Length of prison sentence, Lithuania in 2006 (in%)

Less than one year	10.0
from one year to less than three years	32.3
from three to less than 10 years	43.7
more than ten years	12.6
life imprisonment	1.3.0

(Council of Europe, 2007)

4.6% of the sentenced prisoners have been sentenced for drug offences in 2006 (Council of Europe, 2007). In 2005 there were 25 deaths registered in penal institutions, of these 11 were suicides, which means 44% of the death cases were suicide. The suicide rate lies at 13.8 per 10,000 prisoners, which is above the European average (Council of Europe, 2007).

The number of prisoners per custodial staff is 134.5. Of the staff 16.7% is treatment staff, which is both above European average (Council of Europe, 2007).

4.3.1.2 Prevalence of HIV, HCV, HBV, TB and drug consumption

The first HIV infected person in Lithuanian prisons was detected in 1992, until 2000 the numbers increased on a low level. In spring 2002 an outbreak of HIV occurred in Alytus prison, and at least new 291 cases in prison were diagnosed in that year altogether, tests indicating that all infections had been acquired recently. This outbreak was localized only in that one prison and is

thought to be due to injecting drug use and sharing syringes among prisoners (Caplinskas and Likatavicius, 2002; Chaplinskas et al.). After testing all inmates of Lithuanian prisons in May 2002 only two cases were found in other than Alytus prison, and those two inmates had been to Alytus before (Chaplinskas et al.). As a result of this outbreak the number of registered HIV cases in Lithuania doubled within a few months (Chaplinskas et al.). After 2002 the number of HIV cases declined again, in 2008 181 inmates were known to be HIV-infected. About 65% of all HIV-infected people in Lithuania did serve a prison sentence (Semenaite, 2009), and the main transmission of HIV in Lithuania is since the end of the 1990ies injecting drug use, before it was men who have sex with men as well as hetero sexual contacts (Caplinskas and Likatavicius, 2002). Despite rather good knowledge about HIV, prisoners still practice risk behaviours when using drugs (Caplinskiene et al., 2003), a behaviour which is the main factor for the HIV epidemic in Lithuania (Semenaite et al., 2008). Another study found the knowledge of 1,000 inmates regarding possible ways of transmitting HIV being poor altogether. Although sharing needles was correctly identified as one possibility of transmission by the majority, a substantial number of prisoners thought insects bites or casual contacts like shaking hands would transmit HIV as well (Chaplinskas et al.).

The numbers for acute hepatitis C were decreasing from 21 cases in 2000 to four cases in 2008. Hepatitis B also decreased from 63 in 2000 to 18 cases in 2008 (Semenaite, 2009).

Incidence of tuberculosis cases decreased as well, in 1999 there were 143 registered cases and 84 cases in 2007. Problems are occurring due to the increased numbers of multi-resistant tuberculosis (Semenaite, 2009).

During the last years an increase of drug users in prison was observed in Lithuania. The number of drug using inmates increased in absolute numbers as well as in the percentage of all inmates during the last ten years from 6.6% in 1999 to 20.1% in 2009 (Semenaite, 2009). Among the adult women prisoners 27% were drug users in 2002 (Zurhold et al., 2005), while in 2007 it was already 32.9% compared to 17% among the men (Reitox National Focal Point Lithuania, 2008). In 2006 there were 1,488 drug users incarcerated, which was 18.4% of all prisoners (Reitox National Focal Point Lithuania, 2007). In 2006 of all 1392 administered drug tests 51% were positive (Reitox National Focal Point Lithuania, 2007).

Drug users are mainly young people (almost half from the age group 25–34 years). 83% of imprisoned drug users are injecting drug users (Reitox National Focal Point Lithuania, 2007). The number of heroin users decreased over the past years (1999: 81%, 2006: 36, 2007: 45%) while the number of multi-drug users (1999: 9.9%, 2006: 47%, 2007: 40%) and stimulant users (amphetamines, ecstasy) increased (1999: 2.8%, 2006: 8.4%). Cannabis, cocaine and hallucinogens are used rarely. Reasons for the increased stimulant use include the relatively low price, compactness and easy oral consumption (Reitox National Focal Point Lithuania, 2008). The used type of drug changed over the years. Opiates used to be the most commonly consumed drug in 2000 with 81%, in 2007 it was only 44.2%, while multi drug use rose from 10.2% to 41.7% in the same time period. Also the use of stimulants increased on a smaller scale from 2.8% to 8.1% (Semenaite, 2009).

In 2007 there were 152 cases of drug possession in prison, in 2006 there were 123 cases and in 2005 there were 202. According to the Ministry of Interior the decrease is due to the prohibition of receiving food parcels since 2006 because of drugs dealing, so the most common way of getting drugs into prisons is now slinging them, and also brought in by staff in some cases (Reitox National Focal Point Lithuania, 2008). The most frequently found drug in 2006 was heroin (39 cases), amphetamines and methamphetamines (25 cases each), and cannabis (28 cases) (Reitox National Focal Point Lithuania, 2007).

Of all drug use in prison 86.3% are injected (Semenaite, 2009). A study among drug users in Lithuania found that of all drug users 70.8% have been imprisoned at least once in their lifetime. Of those 26.5% reported injecting drug use in prison and 18.8% reported sharing syringes with other inmates when injecting in prison (Reitox National Focal Point Lithuania, 2008).

Estimations by inmates on drug use in prison scales from 1–80%, the majority agrees on 50–70%. Staff estimates the proportion of drug use between 16–50%. According to the inmates less than 10% of drug users start using drugs in prison, according to staff it is less than 5%. Other prisoners stop their drug use in prison, mainly due to financial problems, health reasons or fear of legal or social consequences (Semenaite et al., 2008). Over the years the prison drug use has changed from poppy straw extract, vodka and the psychotropic substances to heroin and amphetamines (Semenaite et al., 2008).

In Marijambolė prison the most commonly used drugs are heroin and amphetamines, because they are injectable and therefore give an instant and strong

effect. Injecting drug use is practiced on a daily base by less than 15% according to inmates' estimations. Heroin is more expensive and less available than amphetamines. Inmates estimate, that around 40 people share one syringe while staff estimates no more than 10 people sharing one syringe. Syringes are used until they are totally unusable; a new one would cost 6–9 packages of tobacco (Semenaite et al., 2008). Although the knowledge on infectious diseases is rather good, inmates are not able to avoid risk behaviour like sharing syringes (Semenaite et al., 2008).

4.3.1.3 National policies and practices on drug dependence in prison

A number of national programmes are in force; e.g. the “national programme of drug control and drug use prevention for 2004–2008”, and there is a state programme each for sexually transmitted diseases and for tuberculosis (Semenaite, 2009).

The “Lithuanian state programme of HIV/AIDS prevention and control for 2003–2008” has eight areas, one of them targeting at prevention of HIV transmission in IDUs, prisons and medical settings (see Amato-Gauci et al., 2006). This programmes aimed at reaching indicators like 80% of incarcerated people should use condoms during long-term visits, 50–80% (depending on the partner) of drug users should use condoms, 85% of intravenous drug users should not share syringes. In the prison setting, most of these indicators were far from being fulfilled in 2006. The authors of the mid-term report on this strategy reckon another outbreak of HIV in prison likely as long as no serious harm reduction measures like syringe provision and OST are implemented in prisons (Amato-Gauci et al., 2006).

In order to avoid drug use in prison, the following drug reduction measures have been implemented:

- Since 2006 the reception of food parcels is prohibited
- In seven prison units x-ray for detecting drugs are operating in 2006
- Workshop on training dogs was organized
- Public police and prison staff patrols to detect smuggling are operating
- In one prison a device for detecting mobile communication was installed
- Co-operation and information between the penal institutions and the Ministry of Interior was established (Reitox National Focal Point Lithuania, 2007).

The UNODC “project on HIV/Aids Prevention and Supervision among Injecting Drug Users and Prisoners in Lithuania, Estonia and Latvia” was

implemented in 2006. The aim is to reduce and stop the HIV/AIDS epidemics and it is funded with five million US \$. The environment should be favourable in order to better implement prevention strategies and supervision activities among IDUs and prisoners (Reitox National Focal Point Lithuania, 2007).

A study on social tolerance was conducted in eight Lithuanian municipalities revealing that of four vulnerable groups the highest tolerance was for those released from prison, followed by HIV infected people, then prostitution and least tolerance was shown for drug users. Professionals of health care, followed by education and social work showed the highest intolerance, younger people being more tolerant than the age group of above 45. This calls for actions to improve these attitudes (Reitox National Focal Point Lithuania, 2007).

Although the Lithuanian legislation allows alternatives to imprisonment for drug users, these alternatives are rarely executed by the courts (Eurasian Harm Reduction Network, 2009).

4.3.1.4 Drug services

During the 1990ies the number of drug users in treatment in the country increased from 12 per 100,000 inhabitants in 1992 to 76 in 1997, and illicit drug use experience among young people also increased considerably from 3% to 15% of youth aged 15–16 between 1995 and 1999 (Lagerspetz and Moskalewicz, 2002).

In prison three rehabilitation programmes are implemented; one for new prisoners coming into penitentiary institutions, one for convicts and one as preparation for prison release. All of these programmes include the topic of drugs and possible harm (Reitox National Focal Point Lithuania, 2007).

Prevention

Information on drugs and possible harm is provided. In 2006 60 sessions with 4,000 participants took place. Also publications with information on infectious diseases were distributed (Reitox National Focal Point Lithuania, 2007).

Testing, Vaccination and Treatment for Infectious diseases

Testing for HIV is done on a regular basis for all inmates; on arrival and before release, also after long-term visits and holidays and once per year for

all inmates (Semenaite, 2009). Between 1998 and 2003 a special unit for HIV-infected prisoners was operating, they were separated from other prisoners. In 2003 the “HIV/AIDS Prophylaxis and Treatment Centre” was established in the central prison hospital (Semenaite, 2009).

In 2002 there was no vaccination for hepatitis B available in women penal institutions (Zurhold and Haasen, 2005). In 2006 vaccination was only available in three prisons (Juodkaitė et al., 2008: 27). Treatment for hepatitis C is possible for a limited number of prisoners (Eurasian Harm Reduction Network, 2009). Testing for tuberculosis is done regularly on admission and also later during imprisonment (Juodkaitė et al., 2008).

For all tests consent of the inmate is obtained but doubts are mentioned on how properly this consent is obtained in reality (Amato-Gauci et al., 2006).

OST

Detoxification is available in all 15 institutions (Semenaite, 2009) but OST is not offered in any Lithuanian prison, which might be due to opposing policy (Amato-Gauci et al., 2006). In a survey among inmates and staff in Marijampole prison only a minority reckoned methadone treatment as useful. Resentments concern a possible encouragement to start using drugs and to prolong dependency, others state the negative opinions are due to a lack of knowledge (Semenaite et al., 2008).

Harm reduction

Condoms are only given out for long-term visits; otherwise condoms are not available. A survey among 1,000 inmates in 2004 revealed that only 10% used condoms when having sexual contacts (Amato-Gauci et al., 2006).

Bleach is available in prison since the HIV outbreak in 2002 (Chaplinskas et al.), but inmates are afraid of being seen, caught and penalized while using it and therefore only wash syringes with water, if at all (Semenaite et al., 2008).

There is no way to obtain syringes in prison in a legal way, although inmates rate syringe exchange as a useful measure, if access would be anonymous and users won't get punished when getting a syringe (Semenaite et al., 2008).

The implementation of more harm reduction measures in prison is strongly recommended by the authors of the mid-term evaluation of the ‘programme

for HIV / AIDS prevention and control for 2003–2008’ (Amato-Gauci et al., 2006: 65).

Other treatment

Psychological treatment and counselling is offered to drug using inmates, aiming at social and psychological rehabilitation. An individual programme called “behaviour-conversation-change” is applied (Semenaite, 2009).

In four prisons rehabilitation centres are implemented, in seven prisons Alcohol Anonymous (AA) and Narcotics Anonymous are working with the 12-step Minnesota principle (Semenaite, 2009).

In Panevezys prison there are two addiction treatment and psychological rehabilitation centres with together 12 alcohol-dependent prisoners and 18 with drug dependency. In these centres (one for first-time convicts, the other one for re-incarcerated people) the inmates can stay for one year, if they attend the 12-step programme and sign the rules of the centre. Two psychologists are working in the two centres. The number of inmates’ applications for the centres is rising (Stankuviene, 2009).

In Marijampole prison inmates and staff reckon medical and psychological treatment as the most successful in treating drug users in prison (Semenaite et al., 2008).

Drug-free wings are available in women prisons in Lithuania, as well as peer-support and self-help group. A therapeutic community is offered in one of the two women prisons and counselling, external drug services and short-term intervention is available in both (Zurhold and Haasen, 2005).

Services are not especially targeting at stimulant-type drug users in prison despite rising prevalence; these prisoners might have other needs than e.g. opiate users. This includes treatment of withdrawal symptoms as well as psychosocial interventions available outside prison (Decorte, 2007).

Of the 111 beds in the prison hospital 25 are for psychiatric patients and of that five are for people with substance misuse problems (Juodkaitė et al., 2008).

Throughcare

A legal and social education programme for all inmates to be released from prison is provided. This includes information on drug harm, legal and social consequences, mental health, the spread of HIV/AIDS and preventive meas-

ures against it. On release prisoners get information on drug treatment options outside (Reitox National Focal Point Lithuania, 2007).

4.3.2 Results from field visits in Lithuania

Field visits included interviews with the governors, social worker, nurses, doctors, members of NGOs and focus group with female and male prisoners. The field visit took place between 9–13 February 2009)

4.3.2.1 Vilnius Correction House No. 2

Interview with governor and deputy

Vilnius Correction House No. 2 has been renovated since two years. It is situated in Vilnius near a monastery. For many years during the Soviet times it hosted alcohol-dependent patients for up to two years.

At the moment of the visit 477 prisoners were held in Vilnius Correction House No. 2, among them 165 convicted for murder. The number of prisoners in general is stable (between 450–480). In the last 2.5 years no deaths in the prison occurred.

Approx. 15% of the prisoners use drugs, either inside or outside (the most preferred drugs are opioids, amphetamines). According to the management drug addicted prisoners are using those substances which are available, approximately 40 persons are using drugs permanently. The security officers can get hold of a growing amount of drugs, mostly thrown over the wall from the road outside.

Home made alcohol is also an issue of concern. In 2008 approx. 6–7 times alcohol has been detected. The number of drug users has remained stable in the last years.

The social circumstances around drug use, like trafficking, debts, bargaining, putting pressure on parents, partners and friends, and violence are a major problem for the prison management.

Drug users are not kept separately. One central problem with drug users is that they can hardly be approached because they don't admit that they are drug users, and thus cannot be contacted and motivated. Many avoid official help contacts, they try to stay and get clean on their own.

Interview with the prison doctor

The prison health care service (nurse) is accessible 24 hours per day, from 8am – 5pm doctors are present. Doctors of several specialities are there: family doctors, dentists, internal, psychiatrist are covering primary health care, for secondary health care the prison hospital in Vilnius is responsible, for tertiary health care specialists in the community (University clinic).

All prisoners are seen at the entrance, and all are tested for HIV, syphilis plus dentist and health care. Prisoners get a pre- and post test counselling. The test is obligatory by order of Ministry of Justice and Health. Most of the prisoners do not refuse the test. Currently there is no HIV-positive prisoner in the prison. The HIV-test is for every incoming prisoner, only for those who stay longer, it will be repeated after one year, and for those who are released it is done as well. The prison department of the Ministry of Justice pays for the tests. The prices for the test kit are increasing massively in the last years.

Regarding TB prevention there is a programme that observes all prisoners, ‘suspicious persons’ from risk groups are being x-rayed (drug users, lung disease patients) – the trend of active TB is decreasing. The doctors send TB-infected persons to the hospital for treatment.

HBV and HCV testing is done on suspicion as well, especially for the drug using prisoners; 38 HCV – positive prisoners (for these treatment is finished) and 19 HBV – positive prisoners started treatment in hospital.

According to the doctor the major health problems are:

- adherence (“Prisoners do not listen to what is said by the doctors”)
- dental problems.

All in all prisoners are supposed to have better possibilities inside prisons to access health care services than outside. They get medication free of charge, and get access to specialists. Prisoners with self harm symptoms have been transferred to psychologists.

According to the interviewees sexual contacts among prisoners happen occasionally, but not massively, being an important issue for the prison medical service. Condoms are available in the conjugal visit room and at the doctors practice room. At the lectures on HIV/AIDS – prevention prisoners also get condoms.

Tattoos are forbidden in prisons, all incoming and outgoing prisoners are photographed. However, there is no punishment when tattoos made in prisons

are detected at the end of the sentence. Only tattoos detected during the course of the sentence can be punished (orally, forbidden to go to meetings, go to the isolation unit for up to 15 days).

In 2008 there were two prisoners treated with ARV. The treatment started in the hospital. The nurse gives out medicines. According to the respondent drug use seems not to be a problem.

The doctor states that there are good cooperation relations with outside health and social agencies, especially the Vilnius hospital. They see patients with withdrawal symptoms, but the detoxification is done without any medication. They are sent to the psychologists. In very rare cases some medication is given (e.g. pain killers).

Focus Group

According to the participants of the focus group (10 participants) the HIV-test is perceived as obligatory. The prisoners report that those prisoners who refuse the test are being sent to Alytus prison (where the HIV-outbreak happened in 2002)⁸. Alytus prison is perceived as a prison with a strict regime and therefore deterrent to the prisoners. Moreover it holds most of the HIV-positive prisoners in Lithuania and HIV-positive tested prisoners are transferred to that prison.

All drugs in all qualities are available in the prison. The street nearby the prison is the main entrance route.

Heroin and amphetamines are used intravenously. Needles and syringes are rinsed with water. Disinfection is generally possible, but officers can observe access to disinfectants and thus have suspicion for drug use.

Up to 30 prisoners are sharing syringes amongst each others. One syringe (sterile, originally packed) costs 30€. Lending and renting of needles and syringes often takes place. The punishment for detected needles and syringes is isolation for up to 15 days (1st time). For second time offender: separation from the others, no access to any meetings.

8 By order of the Ministries of Justice and Health an HIV test is recommended – the patient has the right to refuse. This order obliges the medical staff to suggest to prisoners to undergo an HIV test. According to the Medical Division of the Lithuanian Prison Department the reasons for transfers are based on the specific sentence and prison regime and not on the HIV-test-result.

Actually there is no group on safer drug use or other harm reduction measures, only AA and NA offer groups.

According to members of the focus group approx. 50% of all prison inmates are users of illegal drugs. It is quite uncommon if somebody doesn't use drugs. It is not difficult at all to acquire drugs. Intravenous drug users all are dependent. After week-ends approx. 15 persons are taken to drug inspection.

Asked about the difference in estimating the prevalence of drug users by the management and by prisoners, it is said that 40 prisoners admitted officially having used drugs.

Prison guards get information from prisoners who are using drugs. They then check the cell including urine testing. Refusals result in punishment.

According to the members of the focus group prisoners don't share razors; scissors are just for the hair cutter.

Pornographic materials and equivalent DVDs are taken away. Sexual relationships between prisoners are happening. According to the prisoners the access to condoms is only possible via conjugal visit rooms. This room can only be used by prisoners who are married and have the chance to get these visits.

Sometimes people from AA and NA are not allowed to get into the prison (ex-addicts/ex-prisoners). The rehabilitation centre (for eight prisoners, they have two rooms with four beds each) is separated from the others, and is better and equipped more modern. The treatment programme follows the 12-step Minnesota programme.

According to the members of the focus group OST should be made available at least for detoxification purposes. If an IDU is arriving in prison, he is put in a separate, primitive room, where no medication is delivered. OST should already be given in police detention and arrest houses.

Asked for the introduction of needle exchange programmes (NSP), the members of the focus group heavily support this measure. According to them bleach should be stored in the toilets, invisible for the guards.

People who are selling drugs are strictly against methadone. This has been confirmed by all members of the prisoner focus group.

According to the focus group members there is no assistance for preparation of release.

Inmates are not allowed to get outside for furlough or for leave. All inmates are very cautious to get known as drug user, because they fear the stigmatisation in the records, and this has implications for work and other services they could not apply for properly (e.g. job in the factory) during their current sentence. Everybody hides that he is a drug user, because he fears negative consequences on various levels.

HBV and HCV testing is offered, but according to the group members it costs up to 200 litas. HCV-testing is not obligatory.

Participants of the focus group want “therapy instead of punishment”, decided and allocated at the court. This would mean that their sentence would be suspended until they finish drug treatment.

As a main problem identified by the group members is the stigma “Narkoman”. This term is leading to a negative attitude towards all those who are drug users or addicts.

All in all a huge difference can be identified between official views on the size and scope of the drug problem and the responses to the problem and the views of the prisoners participated in the focus group.

Interview with members of an NGO

Working as self help group in prisons, the two interviewed members of “Pusiaukelis” are partly funded by the UNODC project, trying to bring ‘good examples of ex-drug users/prisoners’ into the prison. This means that ex-addicts, who ‘made it’, managed their life after release successfully.

They are actively working in Vilnius and Alytus prisons since 2008. Every Friday in Vilnius, every 14 days in Alytus prison. The access for prisoners in Vilnius is as follows: Anyone can get to their meetings. On the average 20 prisoners are attending the meeting. In the group they feel very well accepted. The prison staff supports their activities. In Alytus approx. 50 prisoners attend the meeting every week. They are the only NGO working in the drugs field. They are working on the basis of NA, but let prisoners bring in their own themes.

According to the two interviewees OST should already be given in police detention. Both NGO activists state that there is a programme and a time table for the meetings, but each step has a certain theme.

They state that approx. 10 prisoners share the same needle. They point out that the Alytus ‘accident’ (HIV outbreak) may happen in Vilnius as well. The disinfectants lying out in the ‘living/leisure room’ are supervised by guards, so nobody would make use of it.

Generally they state that there is no understanding of the character and dynamics of IDUs.

As major health risks the following is perceived:

- dental problems
- withdrawal symptoms

Drug use seems to be widespread especially on week-ends. Some prisoners don’t care about punishment, others think they can cheat and others hope not to get identified.

Regarding sex in prisons the two interviewees state that this is a common payment for cigarettes, protection, and drugs. 50 prisoners are placed in one section.

Both are stating that they would go to more prisons and starting self help groups if they were funded, or split up the group in Alytus into two groups, because it got too big already.

Interview with psychologist and social worker

The social worker was not able to give an estimation of the number of drug users in prisons because they fear any number can be misused as justification for introducing OST in Vilnius prison. The interviewees are strict against this offer, because both think that being ‘clean’, which means also without any medication, is the only way to manage opioid addiction.

The psychologist and social worker are running the rehabilitation centre for eight prisoners. The basis principle of their work has been introduced by the ‘Atlantis model’ – similar to the NA philosophy. The rehabilitation programme is divided into 3 phases:

1. information, introduction, lectures, groups, videos; anyone can attend (2 months)
2. those with motivation for a change are taken to treatment, now intensive motivation, like in-patient therapy. Eight prisoners have privileged housing (two 4-bed – rooms in high quality, access to common kitchen, class room, meeting room), relationships with

families, partners are made more easily possible. Visit of schools are promoted, on the basis of AA and NA. Key element is the delivery of a safe environment for personal development, psycho-drama, ‘Gestalttherapie’, cognitive therapy, (12 days after 12 steps) are methods being used.

3. continued therapy offers for those who are successfully working with means of Minnesota and Atlantis. Individual therapy.

The stages 2 and 3 are so called contract – stages, which means that prisoner have to agree by a contract with the goals of the therapy. Anyone can enter the programme – it does not need the diagnosis of psychiatrists as being drug addicted.

At the moment all 8 places are covered. There is a rotation: approx. 13 prisoners go through the rehabilitation centre per year. The programme exists since 2004.

4.3.2.2 Women’s prison Panevezys

Interview with the deputy governor

The prison holds 250 female prisoners, of whom are approx.

- 100 opioid/illegal drug users – 25 of these are dependent and are actively using drugs in the prison
- 72 alcoholics.

Panevezys is the only women’s prison in Lithuania. In the year 2008 259 prisoners were going through the system, about 60 new entries, which means that there is little rotation. There is no overcrowding in the prison; the official capacity is 434 places.

The average length of sentences is 20 months. The average length of court sentences is 54 months. Approx. 1% of the inmates are coming from abroad (Russia, Belarus, Ukraine, and China). There is one mother and child unit. At the time of the visit 10 mothers with their children (up to 3 years) were living there.

Prisoners can be arrested for up to 90 days (in an arrest house unit for 26 persons). Pre-trial is operated in another prison.

Long term meetings (conjugal visits) are allowed. Often husbands are leaving their incarcerated partners so that only a very small percentage uses conjugal visits. This is possible up to 48 hours. The goal is to maintain marriage and

social relationships to partners and children. 61 prisoners are married, 14 of the husbands are imprisoned themselves. Long term meetings are also possible between couples both imprisoned.

The Drug Strategy and HIV/AIDS Strategy of the Ministry have been designed before they have been released officially. In 1997 the 12-step-Minnesota model has been introduced, shortly after the Drug Free Units.

Two rehabilitation centres exist for each house (House No. 1 for first time offenders, House No. 2 for several times offenders). Prisoners of both houses work and eat together, sometimes learn together at school classes. Prisoners are interested to get into the rehabilitation centre first. But before that they have to participate in the NA-group for 3 months and then they proof motivation for the rehabilitation centre. In 2008 13 first time offenders and 53 several time offenders were running through the rehabilitation centre.

The increase of drug use affects all units and the work with prisoners. The motivation of many prisoners regarding continuation of work, qualification and treatment is lacking. Drug using prisoners have difficulties in attending groups and staying there.

There are up to 16 inmates in one room – on the average 6–7. Again in the rehabilitation centre the conditions is are much better: there are only four beds in one cell. At the time of the visit there were four prisoners below 18 years.

Work facilities: a filial of a State company is providing the prison with sewing and other works. On top of that kitchen and garden work is possible. Six prisoners are working in outside companies.

Focus Group

According to the members of the focus group (11 women) the prison based health care system is perceived as the same as under Soviet times. The health services are clearly identified by the interviewees. The dentist service is offered 2 hours per week. The dentist service is perceived as awful and as a 'night mare'. The perception is that the dentists don't treat the teeth, just pull them out immediately. According to the prisoners no medication for plumbs is available. Often a discontinuation of started treatment is described by several attendees. There is a possibility to go out and let the teeth done outside, but it is difficult to finance for the prisoners, there are also difficulties in the organisation and procedures. There is a long waiting list for the dentist (one

participant all three months). Participants complain about the fact that no date to treat acute pain is available unless the patient is crying and with tears in her eyes.

In the prison the interviewees see no market for syringes (in opposite to the men's prison). Prisoners fear to wash syringes because they fear being seen, caught and punished. The consequence is that if they use they are using syringes several times and sharing them several times. Prisoners do have access to disinfectant called Chloramin[®], but this is supposed to be not strong enough to clean the virus effectively. None of the interviewees would clean her syringe in the 'bucket', a device that contains the disinfectant liquid.

According to the prisoners the HIV test on entrance is obligatory for all prisoners, for those who are moved, or after long term visits, the test is done afterwards or every 3 months. If there is no movement, the HIV-test is done once a year. If someone refuses the test she will get a report in her record or go to the medical isolation.

Participants express their own interest in getting tested, and indicate that they are interested in their HIV-status. HBV vaccination is offered. Some participants of the group got vaccinated in prison, some outside, some are immune. Information and education is perceived as good by the interviewees, e.g. done by prison doctor on World AIDS Day 1st December.

The prevalence of drug users is not known, estimation are difficult and can only be given for the specific house the interviewees are living in. For example the situation in one house was described as follows: out of 100 prisoners, 80 are drug users, 20 are not. Drugs are not easily available. Smuggle needs to be carefully organised, then drugs are also accessible.

Interviewees see the practice of urine tests as a control strategy of the prison to detect drug use. Urine tests are done on suspicion, a manipulation is done from both sides: bluff from officers, cheating from prisoners.

The most often prescribed medications are Paracetamol[®] and Aspirin[®].

TB x-ray is done when prisoners are entering the prison. A repetition is done once a year. The TB ongoing treatment was criticised as not exhaustive enough.

In the attitude and even active responses a negative attitude and prejudices against the stigma 'Narkoman' can be noticed. Participants feel the stigma, doctors express it even personally.

Medication from outside cannot be sent by post, but has to be delivered personally. This makes it difficult, as female prisoners come from all over Lithuania. According to the interviewees guards don't want to check the packages, therefore don't allow packages to be sent.

The attention of doctors needs to be changed as well as the whole health care system. Interviewees express their concern that doctors are just sitting in their rooms serving their hours.

Police custody and the situation of withdrawal are described as very important issues in prison lives for drug users. Usually no medications are given, 'cold turkey' is normal.

Prisoners feel that drug users are not given any medicine, just because they are drug users, and health care staff fears unpredictable interactions because they are drug users.

The prisoners discuss "cold turkey" (withdrawal) controversially. Some of the focus group members see the benefits in that it's better to use no medication, which is perceived as quicker. Other members say they need medication also to assist them in sleeping. There is a consensus in the group that women should be given the choice of either or.

Methadone should be used to ease withdrawal pains, already in police custody or in the arrest/pre-trial house.

Complaints in any way are seen as hopeless and as a longstanding procedure leading to nothing. The results of complaints most prisoners do not experience during their current sentence, because they are released before the decision is being taken.

The introduction of needle exchange programmes is mostly seen as strengthening control over drug using inmates.

Interview with the prison doctor

Two doctors are leading the health care service (one therapeutic oriented and one family doctor), both are employed full time. The division of labour among the two doctors is done as follows: the family doctor is responsible mainly for health care service for adults and children, and the therapeutic oriented doctor is mainly treating adults.

Six nurses are employed for the health care service: three for mother and children, and three for the remaining adults. In part time jobs dentist, psychiatrist and gynaecologist hours are involved.

The prison doctor sees three major health problems:

- psychological health
- digestion problems
- gynaecological problems.

The access for prisoners to the health care system is by waiting lists maintained by guards, and acute diseases can be treated at any time (between 8am–8pm).

Some services are accessible only outside prison. Urgent help if needed is accessible at the local hospital, if there is some time. The Vilnius prison hospital (which holds right now 4 female patients), is the central prison medical unit, which is run as an ambulance for emergency cases and primary health care (with own lab e.g. for urine tests).

Regarding the treatment of TB, HIV and Syphilis there are close contacts with the hospital in the community. Now there are 15 HIV-positive prisoners (2008) in the female prison out of 36 in total (400 HIV tests). Out of 200 TB-tests two prisoners were TB-positive. In 2008 there was a HBV vaccination campaign among prisoners: out of 180 prisoners 40 inmates received vaccination. Also the personnel has been vaccinated. 50 doses are left right now and will be used for vaccination in 2009. There is no money allocated for testing hepatitis anymore. The first patient with ARV-treatment came in 2008 – she was sent to Vilnius prison hospital.

Drug use happens occasionally. In the last year 69 cases of drug use have been detected (the main drugs are amphetamines, benzodiazepines, cocaine and opioids). Seldom injection marks are detected. After withdrawal prisoners go into AA and NA groups.

Self harm happens only from time to time. Sexual contacts obviously are not an issue in the prison for the medical health care service. Also tattoos are not spread in the women's prison, there are no fresh tattoos detected.

The doctor has a list of standard medicines: painkillers, sleeping pills, anti-depressants, that are mainly prescribed. The strength of the prison health care is that it is perceived as better than outside. This becomes especially clear when it comes to urgent medical care, this is quickly accessible.

The weakness of the health care system is the financial limit, e.g. first patients are transferred to the hospital in Vilnius then eventually transferred to the local hospital out of financial reasons. Another point has been raised that for IDUs it is difficult to get a treatment or support place after being released from prison. The interviewee expressed that inside prison the life of the prisoners is prolonged.

Interviews with members of NGO

The two AA members are leading a group since seven years in prisons, generally three groups are in the community and the fourth in prison and is called “Caravan”. AA is based on the 12 steps programme. AA provides open meetings which interested prisoners can attend. AA work principles are hard to realize in prisons: openness and frankly speaking about the problems, because prisoners give detailed and sensitive information about themselves, which could be used against them. Participants of the group often open up only shortly before they leave. Some of them go to AA in the community or into other communities.

Generally the groups are led by women for female prisoners. But the group for female alcoholics can also be run by a man, because the common alcohol problem is seen as the main concern and the focus lies on the counselling work apart from social or gender topics.

The 12 steps programme is taught with groups, literature, brochures etc, since 70 years. Originally the Panevysz AA group didn’t have enough staff for a NA – group in prisons. Therefore they would need more staff in order to get such a group started.

The AA staff is of the opinion that prisoners should be on leave to visit a local AA group in the community. Only security problems are against this.

4.3.3 Results from inmates’ survey Lithuania

This survey was conducted in two prisons (see chapter 2.5 for description).

4.3.3.1 Description of the sample

In Lithuania 107 inmates answered the questionnaire. 64.5% (n=69) of the questionnaires come from men in Vilnius Corrections House 2 (V2PN) and 35.5% (n=38) are women from Panevezys Correction House (PPN). All were convicted prisoners; no remand prisoners were being interviewed.

The age ranges from 19–57 (N=106) with the mean age at 33.4 years (SD 9.1) and the median at 31. Men are with 34.7 years older than women with 31.2 years.

Most respondents with 68.2% do speak Lithuanian as their mother tongue, and more than a quarter (27.1%) speaks Russian as mother tongue. Furthermore Polish (2.8%), Belorussian (0.9%) and Ukrainian (0.9%) were reported (If people stated more than one mother tongue, only the first mentioned was included into the results).

The education level reveals no statistical differences concerning gender. The majority completed high school, only few visited university (see Table 26).

Table 26 Education, Lithuania (N=107, %)

	total	men	women
no formal education	2.8	4.3	0
uncompleted primary school	9.3	11.6	5.3
primary school	11.2	8.7	15.8
uncompleted high school	18.7	17.4	21.1
high school	43.0	43.5	42.1
specialized school/college	4.7	1.4	10.5
university	3.7	2.9	5.3
uncompleted university	1.9	2.9	0
vocational	4.7	7.2	0

The majority of the sample is single, women are more often married and less often divorced than men (see table 27).

Table 27 Marital status, Lithuania (N=107, %)

	total	men (N=69)	women (N=38)
single	48.6	50.7	44.7
married	17.8	14.5	23.7
having a partner	12.1	13.0	10.5
divorced	17.8	20.3	13.3
widowed	3.7	1.4	7.9

Of the whole sample (N=107) 55.1% do have children, Women have slightly more often children (57.9%) than men (53.6%). The number of children ranges between 1 and 4 children, mean 1.54 children (men 1.4, women 1.7).

4.3.3.2 Imprisonment

The length of imprisonment is rather long (see figure 24, $p=0.002$), with almost one third serving more than five years, and only around 15% with a sentence less than a year. Men do serve significantly longer sentences (42% more than five years) than women (13.2% more than five years).

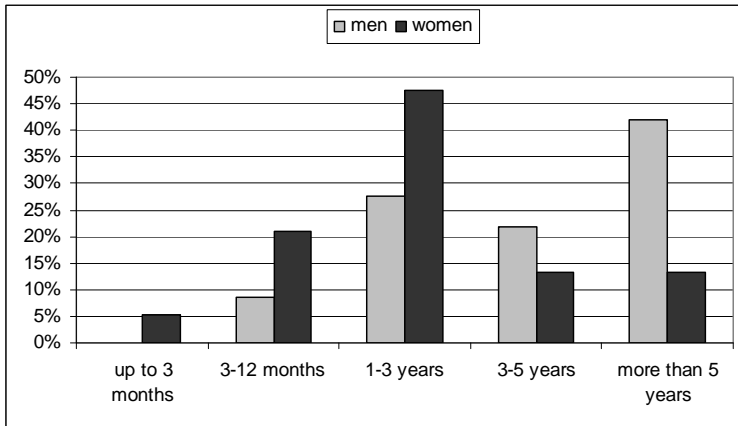


Fig. 24 Length of current prison sentence, Lithuania (N=107,%)

Concerning the time in prison spent so far for this sentence there are no significant differences between men and women (see table 28). The biggest group has been imprisoned for 1–3 years for the current sentence already.

Table 28 Stay in prison on this sentence until now, Lithuania (N=107, %)

	total	men (N=69)	women (N=38)
3 months or less	5.6	4.3	7.9
3–12 months	27.1	23.2	34.2
1–3 years	42.1	37.7	50.0
more than 3 years	25.2	34.8	7.9

Counting together the prison time in the last ten years, they differ significantly ($p=0.000$) between men and women, men having been imprisoned more than half of those ten years, while most women served less than three years (see table 29).

Table 29 Prison time in the last ten years, Lithuania (N=107, %)

	total	men (N=69)	women (N=38)
3 months or less	2.8%	1.4%	5.3%
3–12 months	14.0%	7.2%	26.3%
1–3 years	22.4%	17.4%	31.6%
3–5 years	22.4%	20.3%	26.3%
more than 5 years	38.3%	53.6%	10.5%

The number of times of different prison stays (N=107) varies: The mean is at 2.6 times in the last ten years (men: 2.7, women 2.3), median 2 times (men 2, women 1.5), range between 0 and 10 times (men 1–10, women 0–8).

The most problematic situations/circumstances concerning the imprisonment are given by the prisoners as shown in figure 25 (N=104). The differences between men and women are not statistically significant, although there are some differences: Men state more often the prison restrictions as most problematic ('suffering from' most) and also feelings of depression, while women suffer slightly more often from the separation of their children and are more often afraid of the prison release.

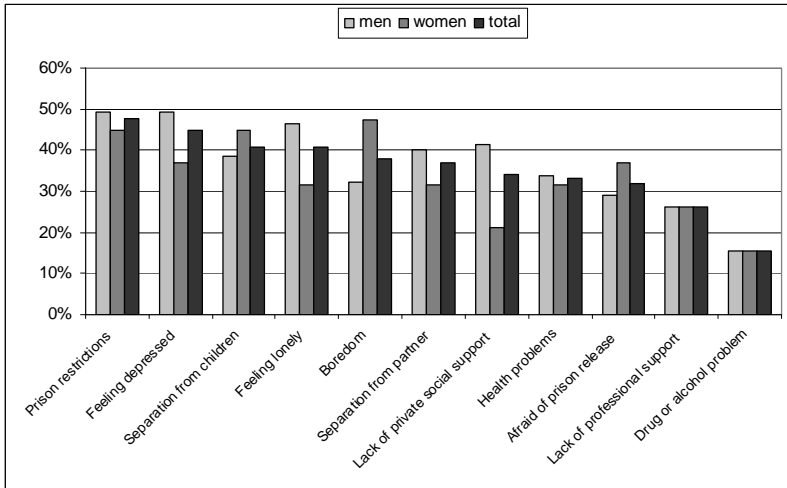


Fig. 25 Suffering from prison situation, Lithuania (N=10,%)

4.3.3.3 Health

Their physical health was rated by the inmates better (41.1% very good or good) than the psychosocial health (31.1%). Women rated their health status much better than men, and more of them said to have no health problems, although some women are rather severely ill (more HIV and HCV).

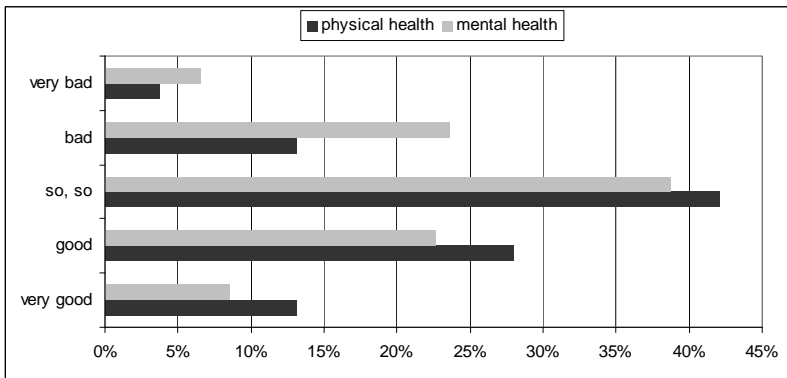


Fig. 26 Rating of own health status, Lithuania (%)

The HIV rate is at 6.5% and almost double for the female respondents. Also significantly more women are affected by hepatitis C (see figure 27), whereas for hepatitis B and tuberculosis almost no differences occur.

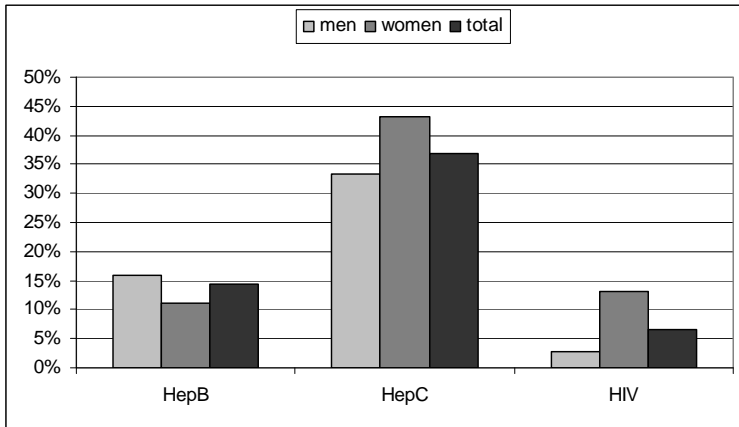


Fig. 27 Infectious diseases, Lithuania (%)

Of those inmates who have a HIV or HCV infection, only one respondent states to get antiviral hepatitis treatment and none is in HIV antiretroviral treatment. Other diseases and symptoms mentioned can be seen in table 30. A remarkable proportion of inmates states to have no health problems, half of the women and a quarter of the men.

Table 30 Other diseases in the last 30 days, Lithuania (N=107,%)

	total	men	women
Depression	47.7	50.7	42.1
Sleep disturbances	45.8	47.8	42.1
Respiratory problems	15.0	10.1	23.7
Epileptic fits	1.9	2.9	0
Tuberculosis	1.9	1,4	2,7
Hepatitis A	0.9	1.4	0
Sexually transmitted infections	0.9	1.4	0
Drug-related overdose	0	0	0
no health or psychological problems	32.7	23.2	50.0

There are only few other health problems mentioned. These include aggression, stomach ache, feeling of dissatisfaction, the decreased amount of food.

4.3.3.4 Drug Use

56.1% of the respondents say, they are (or were) drug user (N=107). The female respondents of the women prison Panevezys Correction House are with 86.8% significantly more often drug users than the men in Vilnius Corrections House 2, where only 39.1% describe themselves as drug users.

To get estimations on the drug use in prison, the inmates were asked, how many per cent of prisoners they think do use drugs in prison. With this, they don't have to admit own drug use but can give their opinion on what is going on. Although the range of answers varies often between zero and hundred per cent for each substance, the mean estimation differs a lot. Generally amphetamines, opiates and cannabis seem to be the most commonly used drugs in prison, while cocaine, crack cocaine and methadone are mentioned to a lesser degree.

Table 31 Estimations on drug use in prison, Lithuania

	Mean	Range Percentage	Don't know (% of all N=107)
Cannabis (N=38)	41,5	0–100	59.8%
Alcohol (N=30)	25.2	1–100	64.5%
Heroin/Opiates (N=53)	51.1	10–100	46.7%
Sirke (Poppy straw) (N=13)	39.6	0–100	80.4%
Cocaine (N=14)	18.3	0–99	79.4%
Crack/Freebase (N=9)	20.9	0–60	84.1%
Amphetamines (N=57)	62.1	5–100	41.1%
Methadon/Buprenorphine (N=9)	16.0	0–50	83.2%
Benzodiazepines (N=15)	37.1	0–100	77.6%
Ecstasy (N=21)	30.7	0–100	72.0%

Comparing the own drug use of the questioned inmates with their estimations on prisons drug use, the prevalence of own drug use in prison is much lower, but the ranking order is the same with amphetamines, opiates and cannabis

being the most frequently used drugs in prison, apart from tobacco and alcohol.

Women do use opiates much more often than men outside prison, less often poppy straw (sirke) cocaine and amphetamines, for all other substances there are no big differences between men and women (see figure 28). Striking are the differences for the drug use in prison; Women report far less drug use inside prison than the men, even if they report more consumption outside, e.g. for opiates, 'sirke' and amphetamines.

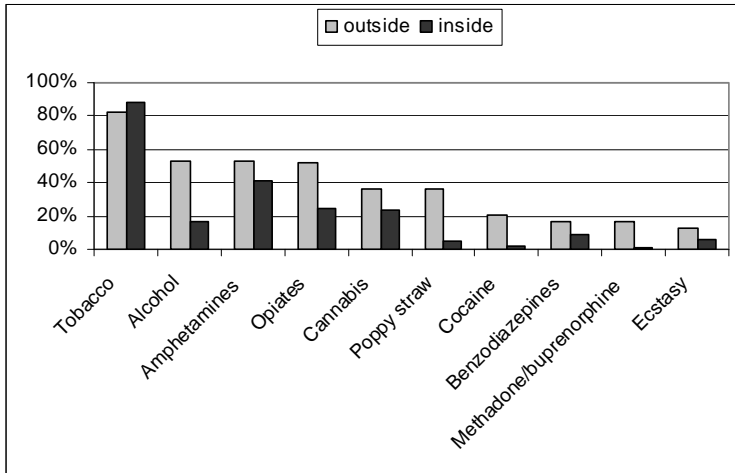


Fig. 28 Substance use, Lithuania (% of all 107)

The route of administrating of drugs in prisons is predominantly intravenously for opiates and poppy straw as well as for amphetamines (see table 32). The latter is also snorted rather often, while benzodiazepines and methadone or buprenorphine are predominantly taken orally. Because of the small number of answers no differences between men and women can be drawn.

Table 32 Route of administration, Lithuania (% of substance)

	inject	smoke	snort	eat/rink
Cannabis (N=38)	0	97.4	0	2.6
Alcohol (N=31)	3.2	3.2	0	93.5
Heroin/Opiates (N=33)	63.6	9.1	27.3	0
Sirke (Poppy Straw) (N10)	90.0	0	10.0	0
Cocaine (N=8)	25.0	37.5	37.5	0
Crack/Freebase (N=5)	20.0	80.0	0	0
Amphetamines (N=49)	55.1	2.0	38.8	4.1
Methadone/Buprenorphine (N=4)	25.0	25.0	0	50.0
Benzodiazepines (N=16)	6.3	0	6.3	87.5
Ecstasy (N=10)	20.0	10.0	10.0	60.0

Although not allowed, the acquisition of drugs in prison is perceived mainly as easy or very easy by 60.6% of the respondents and 39.4% say it's very or rather difficult. There are huge differences concerning this question between men and women; In the men's prison it is perceived as much easier, while in the women prison it seems to be rather difficult (52.8%) or very difficult (38.9%) to acquire drugs, men rating this only 8.8% and 2.9%, the difference being highly significant ($p < 0.000$).

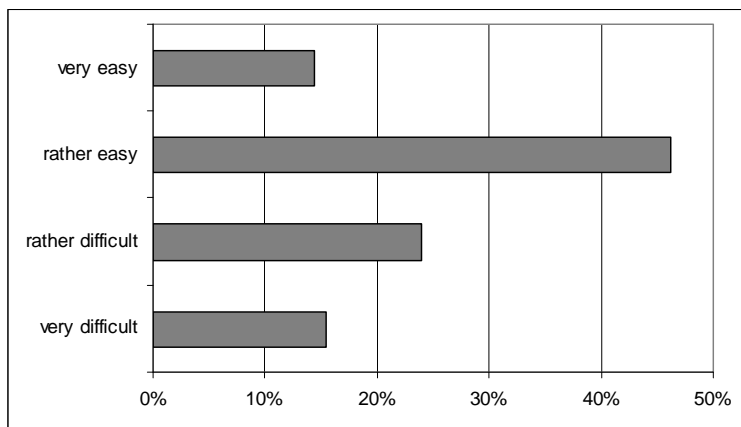


Fig. 29 Acquisition of drugs in prison, Lithuania (N=104)

4.3.3.5 Risk behaviour

Risk behaviour may lead to infectious diseases, especially when harm reduction measures are not readily available. The multiple use of the same syringe can lead to problems for skin and veins. The majority of the sample (71.8%; men 66.7%, women 82.4%) does not inject in prison. Of those n=29 inmates who do report injecting 69.0% report using a syringe multiple times and only 13.8% do not use it more than once.

It is not surprising that inside prison the inmates do share syringes and injecting equipment more often than outside, as supplies are difficult to get. In terms of harm reduction and infection control this calls for adequate measures such as syringe exchange.

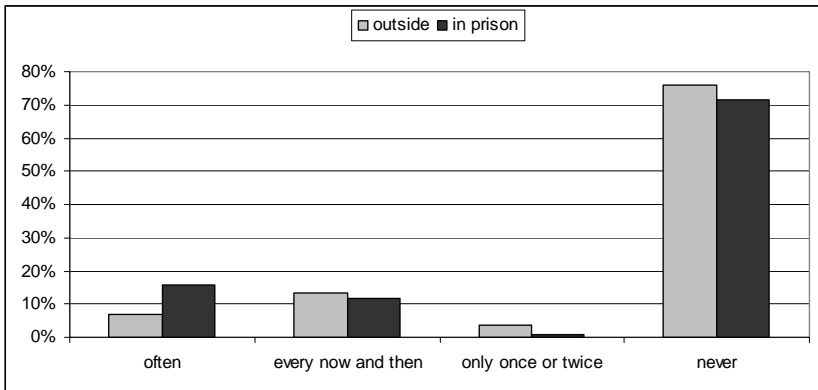


Fig. 30 Syringe or equipment sharing, Lithuania (N=104)

There are significant differences between men and women concerning syringe sharing in prison, with 23.2% of the men stating to share often and none of the women ($p=0.0001$).

Asking the inmates on the situation in prison concerning such delicate issues like sexual activities and violence allows them to give their opinions on the prison situation without admitting themselves to such activities. Asked for the percentage of prisoners having sex in prison, the mean estimation lies at 30.6% ($N=33$, range 1 – 100), while a high proportion of inmates (69.2%) state not to know. The issue of paying for sex in prison the estimation lies at 25.2% ($N=26$, range 1 – 100), while 75.7% of the whole sample don't know

about that. The issue of forced sex is even more sensible, only N=14 give an estimation of mean 16.1% (range 1–100) and 86.9% of the sample say they don't know about it.

Violence can appear in different forms, and psychological violence is perceived by the prisoners as the most common with 66% compared to 52.9% confirming the existence of physical violence and still 36.3% sexual violence (see table 33). There are great differences between men and women, the latter telling of all kind of violence significantly less often than men.

Table 33 Estimation on violence, Lithuania (%)

	yes		no		don't know	
sexual violence (N=102)	36.3		25.5		38.2 (p<0.000)	
	men	women	men	women	men	women
	50.7	6.1	18.8	39.4	30.4	54.5
other physical violence (N=102)	52.9		16.7		30.4 (p<0.000)	
	men	women	men	women	men	women
	66.7	24.2	14.5	21.2	18.8	54.5
psychological violence (N=106)	66.0		7.5		26.4 (p=0.004)	
	men	women	men	women	men	women
	75.4	48.6	8.7	5.4	15.9	45.9

Asked for their own risk behaviour, the answers are as shown in figure 31. More women report having piercings made in prison and sexual contacts while more men have tattoos made and share razors, but only the difference in tattooing is significant (p=0.0001).



Fig. 31 Own risk behaviour, Lithuania (N=107)

37.4% of the whole sample (N=107) did have conjugal visits. Among the men 42% reported conjugal visits, at the women’s prison 28.9%.

4.3.3.6 Help Services

A treatment plan or care plan is not available for most of the prisoners as far as they know of. Only 11.5% know of a treatment plan, and 9.7% of a transitional care plan. 16.3% report getting assistance for prison release. There are no significant differences between men and women.

The quality of the health care treatment is assessed by the prisoners as mainly bad or even very bad (83.2%), and women rating the quality worse than men with 89.4%.

Numerous help services are offered in Lithuanian prisons. Although one respondent claims to be in substitution treatment, this is actually not possible within the prison system. The number reporting substitution treatment outside prison is also rather low with 6.6%.

Different services were assessed by the respondents, whether they are available in prison or should be available, as can be seen in figure 32.

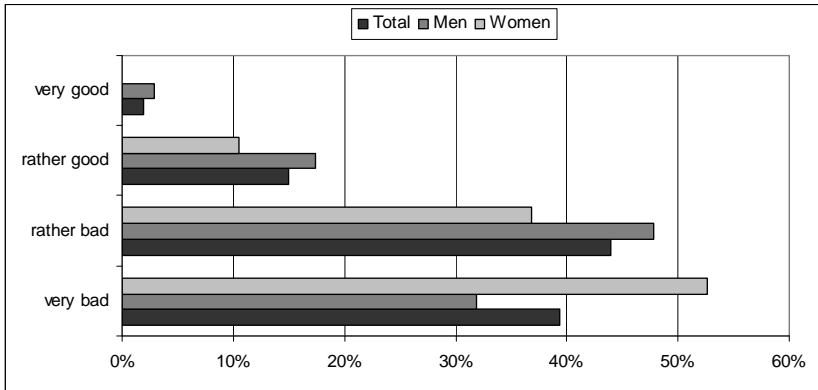


Fig. 32 Assessment: Quality of health care in prison, Lithuania (N=107)

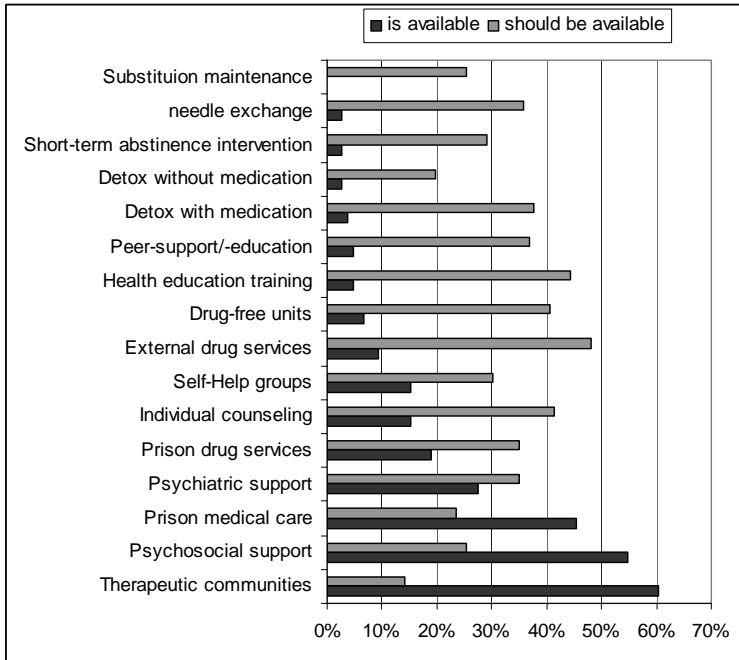


Fig. 33 Availability of help services in prison, Lithuania (N=106, %)

Striking in this issue are the relatively high numbers (more than 40% for each item) of prisoners who wish to have health education, drug-free units, individual counselling, and especially external drug services.

Both questions for the availability and utilization of help services in prison reveals some discrepancies between the prisoners' answers and the actual available services. Namely substitution treatment and needle exchange services are not available in Lithuanian prisons, although prisoners state to have used those. There is likely to be some misunderstanding, probably due to language (the questionnaires were only in Lithuanian) and/or literacy.

In general, the service utilization in prison is not very high. This could be due to only limited access/availability of those services.

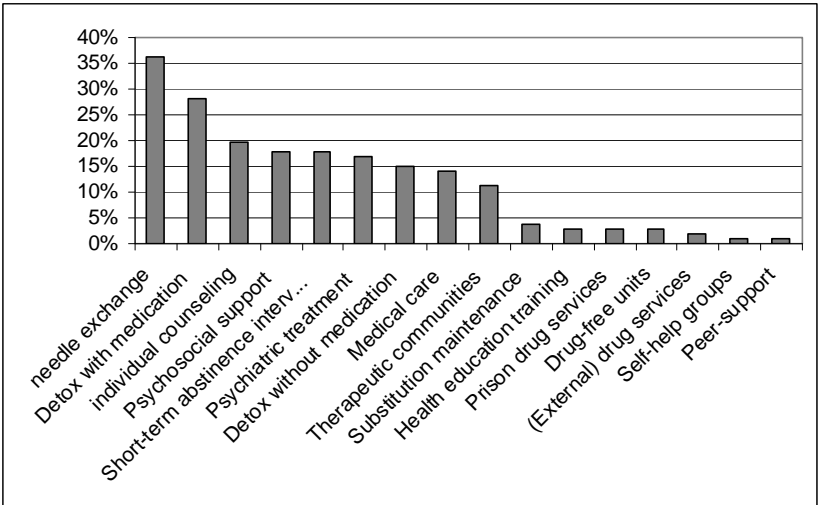


Fig. 34 Services used in prison, Lithuania (in% of all 107)

Outside prison, the utilization of drug services varies. The most common is detoxification (23.4%), counselling (16.8%) and abstinence therapy (16.8%) while substitution treatment (6.5%) or low-threshold facilities (3.7%) are hardly used, likely due to scarce availability.

The prisoners remarked on other topics which they value as important. These remarks can be distinguished into five main areas: medical services, social care, drug treatment, job and education and general remarks.

Medical treatment

Concerning medical treatment the prisoners generally wish better quality of the medical treatment (4 statements), which is described as non-existing by one respondent. The need for dentists is mentioned (2), which only offer help for hard cases as one inmate states, The quality of staff (2) as well as of the medication (3) is mentioned and should be improved according to some respondents, as well as the provision of vitamins. The treatment for HIV and/or hepatitis (2) is referred to as well. One inmate stresses the need of equality of treatment inside and outside prison walls. One demands a separation of prisoners with some diseases.

Social care

The need for psychological and/or psychotherapeutic support is verbalized by seven respondents. Some also stress the need for re-integration into society and for the integration of medical and psychological support, while one inmate reports that psychological staff should not condemn but help.

Drug treatment

One of the more frequent comments on drug treatment in prison is the desire for qualified and medical-assisted detoxification (4 statements) with methadone or buprenorphine, while one inmate claims that they don't need methadone. The importance of medical-supported detoxification with psychological help is stressed. Specialists in drug use treatment are needed (1), and one respondent asks for detoxification treatment in the hospital. One respondent wishes to "to abandon this evil, this habit in moral level".

One inmate requests the separation of drug users and non-drug-users, some others justify separate areas with the continuation of treatment and recovery (3) and the need of rehabilitation centres or areas, where not enough places are provided at the moment (1). The provision of needle and syringe exchange programmes is requested explicitly once.

Some women remark on the different availability in men's and women's prisons, the latter not providing the same treatment opportunities than men, namely 12 step programmes are missing there. Another woman claims that drug use treatment at the women's prison is of no great importance and only minimal support is given, which is not very helpful.

Job and Education in prison

There are a number of remarks on the job situation in prison. Respondents say, there are not enough (speciality) jobs (4 statements), and the pay-off is not enough (3), so that even necessary things like sanitary towels can't be afforded. Others stress the importance of adequate training and education (4) to prepare for jobs outside prison. The lack of social guarantees for the outside is mentioned as well.

General remarks on the prison environment

Some remarks do concern the staff situation in prison, e.g. good, qualified and careful staff is needed (3), contacts with prisoners should be more human and "heartily". Another strong topic is the preparation for release, which is perceived as inadequate by a number of prisoners (6 statements). Some material support is mentioned as well as the need for washing machines. The quality of food and the possibilities for sports and cultural activities are mentioned a few times. The availability of lawyers is needed (2) as well as the chance to get surgical intervention by own money of prisoners. Concluding these issues, the topic of prison release is mentioned very often, as well as the bad quality of medical care and the concern for education possibilities and job opportunities in prison.

4.3.4 Results from the presentation of the results in Lithuania

The presentation of the results took place on 10th of June 2010. Participants/representatives came from the Medical Division of the Prison Department, UNODC, and the chaplain's organisation of Lithuania.

The results of the quantitative study have been presented by a slide – based lecture and then discussed. There was an agreement that the study results showed BBV-relevant risk behaviour (sharing of drugs/equipment and sexual contacts, tattooing), risk exposition of prisoners and some other health related problems. There was also a consensus that the study results require action on several levels.

The discussion about HIV preventive activities were centred around the "Comprehensive Package" WHO and UNODC elaborated (WHO et al., 2009: 6):

- Needle and syringe programmes (NSP)
- Opioid Substitution Therapy (OST)

- Voluntary HIV Counselling and Testing (VCT)
- Anti-Retroviraltherapy (ART)
- Sexually transmitted infections (STI) prevention and treatment
- Condom programming for IDUs and partners
- Targeted information, education and communication (IEC)
- Hepatitis diagnosis, treatment (A,B,C) and vaccination for A & B
- Tuberculosis (TB) prevention, diagnosis and treatment.

Representatives of the Medical Division of the Prison Department stated that except the first two measures (Needle and syringe programmes (NSP) and opioid substitution treatment (OST)), all other activities have been implemented in Lithuanian prisons. There was a discussion about the other activities of the above mentioned “Comprehensive Package”:

Voluntary counselling and testing (VCT) (obligatory or negative consequences on refusal) and provision of condoms were both perceived differently by prisoners (see chapter 4.3.2). Basically it is a problem of availability and accessibility of services (especially regarding condoms, which are available only in conjugal visit rooms and prison stores).

4.3.5 *Conclusions*

Lithuania has a prison population rate of 234 prisoners per 100,000 inhabitants. This is one of the highest rates in Europe.

The epidemiological situation shows a growing number of persons with HIV and AIDS. In this study the self reported HIV rate is 6.5% and almost double for the female respondents. Also there is an increasing number of drug users in the prison population, the numbers tripled within the last ten years. Recent data presented by the Prison Department indicate that almost every fifth prisoner is a drug user, almost two thirds of them are problem drug users (approx. 1,000 prisoners). In our study 56.1% of all respondents said, they are (or were) drug user. Of the women prison Panevezys Correction House are with 86.8% significantly more often drug users than in the men’s prison Vilnius Corrections House 2 only 39.1% describe themselves as drug users.

Measures to control drug use are mainly supply and to a lesser extent demand oriented. Prisoners interviewed are demanding “therapy instead of punishment”. However, the acquisition of drugs in prison is perceived mainly as ‘easy’ or ‘very easy’ by 60.6% of the respondents and 39.4% said it’s either ‘very’ or ‘rather difficult’. This leads to growing expenditures for personal

healthcare of these patients (treatment of diseases accompanying AIDS, increase of mortality in prisons).

Regarding hepatitis the epidemiological picture is less clear. Due to financial constraints patients are not examined for chronic viral hepatitis. In many cases prison medical staff does not have information about patient's treatment before entry into prisons. Due to available budgets only a limited number of patients with chronic viral hepatitis can get treatment – some of the patients have to wait until the treatment is prescribed.

The study results showed enormous BBV infections relevant risk behaviour (sharing of drugs/equipment and unprotected sexual contacts, tattooing), risk exposition of prisoners and some other health related problems.

Also in Lithuanian prisons all forms of violence (sexual, physical and psychological violence) are spread especially among men.

The quality of the prison health care is assessed by the prisoners as mainly bad or even very bad (83.2%), and women rating the quality worse than men with 89.4%.

The reactions towards these challenges by the Lithuanian Prison Department under the Ministry of Justice have to be discussed alongside the UNODC recommendations of a Comprehensive Package.

Despite the comparably high prevalence of drug injecting and other risk behaviour occurring in Lithuanian prison (according to official data, almost 80% of all drug users are injecting their drugs), needle and syringe programmes (NSP) are not yet available. Bleach is available in prison since the HIV outbreak in 2002. However, inmates are afraid of being caught and penalized while using it and therefore often only wash syringes with water.

Also Opioid Substitution Therapy (OST) has not yet been implemented in Lithuanian prisons. However, an inter-institutional working group was set up to prepare procedures for a continuation of substitution therapy: from the society to police arrest houses to remand prisons and back again to the society.

Voluntary HIV Counselling and Testing (VCT) is given according to officials of the Ministry of Justice. One of the main legal acts regulating the control of infections in penitentiary institutions is the 'Procedure from 2 July 2002'⁹.

9 Anonymous (2002). Procedure on preventive examination for infections qualified as risky and of high risk of persons held in the institutions subordinate to the Prison Department under the Ministry of Justice approved by the joint order No343/191 of the Minister of

However, the practice of VCT is seen differently by officials of the Prison Administration and prisoners. Prisoners see that positive results lead to a transfer and probably treatment in Alytus prison.

Regarding Anti-Retroviral Therapy (ART) currently all patients in need of the treatment have access to it. However, due to constant increase of HIV/AIDS infected persons in penitentiary institutions funding for the treatment may fall short.

Regarding sexually transmitted Infections (STI) prevention and treatment, there is not an approved state programme at the moment. However, the Prison Department implements preventive activities and treatment from its own financial resources.

The issue of condom availability and accessibility is also perceived controversially. According to official statements condoms are freely accessible in long-term meeting rooms, furthermore they may be obtained from medical specialists or bought in the penitentiary institution store. However, according to prisoners condoms are only available in conjugal visit rooms and prison stores. This obviously restricts the number of persons who might access condoms. In a recent study only 10% used condoms when having sexual contacts. Basically it seems to be a problem of availability, accessibility and confidentiality of services.

The task to develop targeted information, education and communication (IEC) has been delegated to the Public Health Centres in Lithuania. However, these institutions merely implement monitoring measures only. Therefore the medical specialists and the Prison Department have to provide educational activities and trainings by their own. The problem is that medical specialists are facing heavy workloads, and due to the lack of funding they fail to produce enough of the necessary literature. Recent studies show that the knowledge regarding possible ways of transmitting HIV seems to be poor. Target group specific IEC campaigns are required.

Regarding hepatitis diagnosis, treatment (A,B,C) and vaccination for hepatitis A & B the staff members are being hepatitis B vaccinated. In 2006 vaccination for prisoners was only available in three prisons. Due to the lack of funds only the cases of acute hepatitis are being treated. Examination and

treatment of chronic hepatitis are limited and implemented according to a planned schedule by enlisting patients in a queue.

Finally there is a 'State Programme of Prevention and Control of Tuberculosis for 2007–2010', which is also implemented in prisons.

These developments show that the scaling up of the implementation of evidence-based interventions alongside the UNODC Comprehensive Package is urgently needed in Lithuania. Furthermore both male and female prisoners report of various forms of stigmatization as 'Narkoman' and discrimination.

4.4 Poland

4.4.1 General information on the prison system

There are 86 prisons in Poland, and 70 institutions for pre-trial detainees (Walmsley, 2010b).

The drug law from 1997 did penalize the possession of drugs but excluded cases of small amounts from prosecution. In 2000 the drug law changed under a new government and contained more repressive measures, as since then the possession of small amounts of drugs is prosecuted as well. This led to a significant increase in prosecuted cases from almost 16,000 in 1999 to more than 70,000 in 2006. Another new drug law from 2005 didn't change in this respect. It's not the drug dealer who is prosecuted in the majority of cases but drug users (Krajewski, 2009b). An analysis of court cases revealed that most cases under the drug law concern small amounts and in the majority marijuana. Although the courts are not very harsh in their sentencing, the courts and the prosecutors only reluctantly qualify offences as cases of minor importance. Alternative therapeutic measures, diversion or treatment instead of punishment is hardly ever applied, referring drug users to the treatment system outside the penal system practically does not exist, although possible under Polish law (Krajewski, 2009a).

4.4.1.1 Prison statistical data

There were 84,003 prisoners in Polish penal institutions in January 2010. This means a prison population rate of 220 prisoners per 100,000 inhabitants (Walmsley, 2010b), an increase in the prison population rate since the 1990ies with a slight decrease since 2007, as can be seen in figure 35. The prison density in 2006 was 117.3 prisoners per 100 places, which is an increase of 7.3% between 2000 and 2006, and is a sign for overcrowding

(Council of Europe, 2007), while in 2010 the official occupancy level was 99.6% (Walmsley, 2010b). Overcrowding seems to be a problem of particular prisons, where the occupancy level might be as high as 150% (MacDonald, 2003).

The mean age of prisoners in Poland is 34.1 years which is a little above EU average (Council of Europe, 2007).

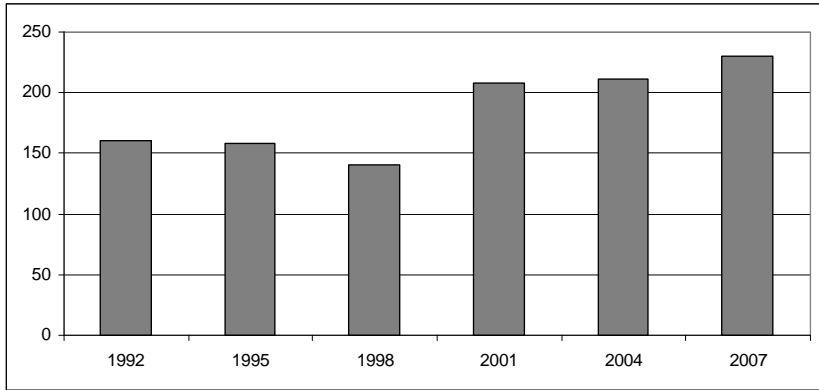


Fig. 35 Imprisonment rate per 100,000 inhabitants, Poland (adapted from Walmsley, 2010b)

In 2010 the percentage of female prisoners is 3.2%, only 0.7% are foreign prisoners (Walmsley, 2010b). 11.3% of all prisoners are pre-trial detainees; they didn't have a court decision yet. Of all prisoners 4.6% are male juveniles and 0.1% are female juvenile prisoners (Polish Department of Justice, 2009).

Table 34 Length of sentences (in%) in 2006, Poland

less than one year	22.8
from one year to less than three years	43.7
from three to less than 10 years	22.9
more than ten years	5.8
life imprisonment	0.3

(adapted from: Council of Europe, 2007)

The prison mortality rate in 2005 was 14.8 per 10,000 prisoners, and the suicide rate 3.9 (Council of Europe, 2007).

15.6% of all prison staff was treatment staff in 2006, which is above the European average at 10.6% (Council of Europe, 2007). Blaauw et al. state a ratio of 160 prisoners per mental health staff and a ration of 2.6 prisoners per all staff in 1997 for Poland (Blaauw et al., 2000). The custodial staff receives some training on dealing with mentally disordered inmates (Blaauw et al., 2000). Staff shortage was a problem in 2002, when custodial staff is working overtime and therapeutic staff is responsible for more and more inmates. The staff shortage in the example prisons was mainly due to financial problems (MacDonald, 2003). The number of prisoners per custodian staff was 1569.3 in 2006 and therefore way above the European average at 771.8 (Council of Europe, 2007).

In 2008 there were 9 rapes inside prison officially reported and 78 cases of bullying, 52 cases of serious battery (Polish Department of Justice, 2009).

According to the Polish Department of Justice, almost 35% of all prisoners (=19,605) are in paid employment, additional 54,862 do have voluntary work (Polish Department of Justice, 2009).

The number of sentences for drug offences increased enormously during the past twenty years from less than a hundred cases in 1990 up to almost 15,400 cases in 2006 (Reitox National Focal Point Poland, 2008).

4.4.1.2 Prevalences of HIV, HCV, HBV, TB, and drug consumption

There were about 25,000 HIV infected people in Poland in 1999, the most common route of transmitting HIV was in 2000 injecting drug use (Drug Law and Health Policy Resource Network, 2002). The prevalence of HIV among injecting drug users remained stable between 1995 and 2001. In 2001 the rate was 0.68 HIV infections per 100,000 inhabitants. The incidence of hepatitis C varies considerably, decreasing since 1993 in Poland with 1.4% per 100,000 people in 1999 (Stöver et al., 2004).

Data on infectious diseases in prison are not available. No official data are collected on Hepatitis C and B in Polish prisons (MacDonald, 2004).

The number of problematic drug users in Poland was estimated in 2003 between 32,000 and 60,000 (MacDonald, 2004). Due to a bad image of injecting drug use there is a decrease in injecting. Also the use of 'kompot' (Polish home made substance of poppy straw) is decreasing while multi-

drug-use patterns and heroin use is increasing, opiates being the main drugs causing problematic use (MacDonald, 2004).

While in 2002 not many drug users were known in Polish prisons (MacDonald, 2003), in 2003 the proportion of drug users in prison was already estimated to be 30%. Another 30% were estimated to have alcohol problems (MacDonald, 2004).

Drug use in Poland has changed considerably both in extent and in terms of the preferred drugs. In the beginning of the 1990ies the prevalence of drug use was low, home-made “kompot” from poppy straw was the most common drug. This has changed to more synthetic drugs (Krajewski, 2003). According to Sieroslawski (2003), there was not a big drug problem in Polish prisons until the mid-1990ies. Drugs are present in prison and seem to be more easily available than alcohol (Sieroslawski 2003 cited in MacDonald, 2004). The first research project on drug use in prison was carried out in 2000 by the Institute of Psychiatry and Neurology, Warsaw. The survey of 1,186 men held in penitentiary institutions all over Poland showed that almost every fifth inmate had been an occasional drug user prior to imprisonment. This figure increased to 30 per cent for those in the age group 17–24 years. Inside prisons 22.5% of all prisoners interviewed and 33% in the age group 20–24 years used drugs, predominantly sedative drugs such as tranquilizers, cannabis-based products and amphetamines. 3.3% of the inmates confirmed intravenous drug use, while 1% reported sharing of syringes (see MacDonald, 2004).

A 2007 survey on drug use in penal institutions revealed that life time prevalence of different substances is high, with marijuana and amphetamines being the most popular drugs. Injecting drug use is reported by 6.7%. Compared to a 2001 survey drug use in prison was lower or similar in 2007 with the exception of ecstasy. Of the inmates who ever used drugs outside 36.5% reported drug use inside penal institutions, while those who reported drug use during the last 30 days before imprisonment almost two thirds (63.8%) reported drug consumption in prison. 4.9% of those not consuming drugs in the community reported drug use inside prison. Drug use in prison was connected with a previous criminal record and with young age (Sieroslawski 2007 cited in Reitox National Focal Point Poland, 2008).

The use of opiates has decreased markedly since the 1990ies (Stöver et al., 2004). The most commonly used drugs are, both in the community and in prison, marijuana and amphetamines. Furthermore cocaine, ecstasy, medica-

tion like benzodiazepines and anabolic steroids are popular. The drug using population in Poland has changed since the 1990ies. Back then they were mainly socially mature and well educated, whereas nowadays the drug users are mainly young people with multiple problem areas, are less well educated and often member of criminal groups. They are often little motivated to actively take part in treatment (Association of Alumni and Friends of the Law and Administration Faculty at the Jagellonian University, 2009).

4.4.1.3 National policies and practices on drug use in prisons

Since 2005 article 62 of the Drug Use Prevention Act is in power. This article says that the possession of any drug shall be punishable with a prison sentence of up to three years, in minor cases also with a fine, probation or shorter sentence, in the cases of larger amount up to eight years. A study on the implementation of this law concludes that this article costs at least PLN 80 million a year. Professionals don't believe in any significant reduction of the drug problem (Kuzmicz et al., 2009). Due to this law the number of drug users in prison is rising (Association of Alumni and Friends of the Law and Administration Faculty at the Jagellonian University, 2009).

The "Polish Punishment Execution Code" from 1997 states that the prison penalty can be served in the therapeutic system (article 81). This is put into practice by offering therapy within the prison system. The court can also decide to put dependent offenders in the therapeutic units against their will (article 62 Penal Code). The therapeutic units aim at social rehabilitation and crime relapse prevention (Association of Alumni and Friends of the Law and Administration Faculty at the Jagellonian University, 2009).

The National Programme for Counteracting Drug Addiction 2006-2010 has a focus on increasing the availability of programmes designed to prevent and treat infectious diseases in drug users (Reitox National Focal Point Poland, 2007).

The 'regulation of the Minister of Justice of 21 December 2006 on treatment, rehabilitation and re-adaptation of addicts in organizational units of the Prison Service' specifies the responsibilities of doctors at outpatient clinics and the therapeutic wards. It is established in this regulation that treatment, rehabilitation and re-adaptation of addicts in penal institutions is conducted at prison outpatient clinics and patients' chambers, detoxification sub-wards of health care centres for prison inmates and the therapeutic wards. The staff in

the therapeutic wards has to prepare the addicts for the time after release and social rehabilitation (Reitox National Focal Point Poland, 2007).

According to the National Focal Point the Central Board of Prison Service spent 2 471 582.42 Euro in 2006 on the implementation of the “National Programme for Counteracting Drug Addiction” (Reitox National Focal Point Poland, 2007).

4.4.1.4 Drug Services

There is range of drug services available in prison, including substitution treatment, prevention programmes and abstinence oriented therapies (Reitox National Focal Point Poland, 2007). The main focus of the prison drug strategy though is on drug supply reduction and control measures (Stöver et al., 2004).

Prevention

Prevention programmes in prison do not distinct between alcohol and drug addiction programmes. They take place outside the therapeutic units. Prevention programmes are very diversified and can cover variable hours of activities. Some measures are implemented by staff, others by people from outside. According to the Ministry of Health 56 programmes were run in 2005 and 286 programmes in 2006, together with 10,083 participating inmates (Reitox National Focal Point Poland, 2007). Staff training takes place on prevention issues (Reitox National Focal Point Poland, 2007).

Testing, counselling, and vaccination for infectious diseases

Testing for infectious diseases does take place on voluntary basis. Vaccination for hepatitis B is not offered to the prisoners in the female prisons (Zurhold and Haasen, 2005), and another survey reports that vaccination is only available for the medical staff (MacDonald, 2003).

In some prisons antiretroviral treatment for hepatitis C is possible but only on a low scale (Reitox National Focal Point Poland, 2007). HIV treatment is in some cases realized within the community. The cost for HIV treatment is covered by the prison budget but will be paid back by the health service (MacDonald, 2003: 29).

Although some prison staff (psychologists, case managers, and some medical staff) has been trained in pre- and post-testing counselling, practice is some-

times problematic, as psychologists are usually not present at the actual testing and medical staff not always trained in counselling, and due to confidentiality referral to a psychologist is not possible in every case (MacDonald, 2004).

Confidentiality on the status of infection is not always maintained, as a survey in 2002 revealed, where medical information wasn't always kept to the medical department (MacDonald, 2003).

OST

Opioid substitution treatment (OST) in Polish prisons is possible since 2003 but due to strict regulation it is very seldom implemented. OST is only possible for inmates, who where in OST before imprisonment and go back there after release. In 2008 there were 34 inmates in OST, 30 of them in the Warsaw region. No prison for female offenders offers OST (Association of Alumni and Friends of the Law and Administration Faculty at the Jagellonian University, 2009). In 2007 four OST programmes were run in Polish penitentiary institutions, each with 15 places maximum. As OST is not always possible in the community in all areas in Poland, continuous care is a major problem, therefore only few inmates get OST treatment, co-ordination is needed (Reitox National Focal Point Poland, 2008). In 2001 only 4% of opiate users were in OST in the community (Stöver et al., 2004). OST is not possible in all prisons; in 2006 there were 45 places for methadone substitution in five therapy wards, another ward was planned to open in 2007 (Reitox National Focal Point Poland, 2007). As a national strategy on OST is lacking, it is difficult to continue OST when referred from one institution to another or between the penal system and the community (MacDonald, 2004; Reitox National Focal Point Poland, 2007). The lack of a national strategy on OST is the main problem in implementing OST in prison more widely (Stöver et al., 2004).

Harm Reduction

Information leaflets on harm reduction are occasionally available for drug using inmates (MacDonald, 2004).

Psychologists and case workers have received training on HIV and harm reduction, which was carried out by NGOs. Additionally staff at the therapeutic units for drug dependent inmates get regular training on HIV, harm reduction and drug issues (MacDonald, 2004).

Condoms are provided in prison shops and canteens, and they are also distributed free of charge, but this does not take place in a systematic way. Due to financial problems, condoms are not available in all Polish prisons (MacDonald, 2004). Sometimes prisoners (e.g. women prisoners) are given condoms for their home leave, but the attitude among male inmates is rather rejecting as they deny any homosexual men in prison and therefore don't see the need for condoms (MacDonald, 2003: 32).

Needle exchange programmes are forbidden in penal institutions (Reitox National Focal Point Poland, 2008). As the incidence of injecting drug use is perceived as low, the prison administration doesn't see the need for neither bleach nor syringe exchange in prison. Nevertheless bleach is to a certain extent available as it is being used to disinfect the cells (MacDonald, 2004).

In 2007 two harm reduction measures were implemented in five institutions (two female, two male and one remand prisons) by external NGOs. The programmes included counselling, motivational interviewing, educational and information classes. 280 inmates participated, including 20–25% injecting drug users (Reitox National Focal Point Poland, 2008).

The NGO called MONAR works in the prisons with drug using inmates, using educational trainings and support self-help. They also provide training for prison staff and help prisoners finding therapeutic communities outside prison (Stöver et al., 2004). No peer-support programmes are offered in female prisons (Zurhold and Haasen, 2005).

Other Treatment

Therapeutic wards for drug users do exist in Polish prisons. Although the number of places was increased in 2006 the waiting time until admission increased as well up to 13 months. Only one social rehabilitation centre was in place for juveniles (Reitox National Focal Point Poland, 2007). In 2006 there were 13 of these therapeutic units with a structured six-month drug-free programme implemented offering 481 places. In 2007 the programme was run in 14 units with 513 places and for 1502 inmates (Reitox National Focal Point Poland, 2008). This is based on a model of psychosocial interactions and the social learning theory, and included elements of the Minnesota model as well as cognitive-behavioural model. In 2006 altogether 1372 inmates participated in this programme (Reitox National Focal Point Poland, 2007). At the end of 2007 1315 inmates have been to the therapeutic units, including 167 women (Nyk, 2009). The proportion of prisoners not finishing the pro-

gramme is less than 10%. Although the conditions in the therapeutic units are getting better each year, there are still not enough places and waiting times are long, even after shortening the programme from 12 to six months. There is staff shortage in the therapeutic units and in some cases the legal staff requirements are therefore not met (Association of Alumni and Friends of the Law and Administration Faculty at the Jagellonian University, 2009).

Throughcare

The continuation of therapy upon discharge from prison is reported to be problematic (Reitox National Focal Point Poland, 2007). Prison staff usually doesn't have the capacities to organize systematic throughcare and release preparation. Similarly social workers from the community are often overloaded with work so they don't have time to organize things with inmates. In some prisons though co-operation with drug services in the community is established and continuation of care can be organized (MacDonald, 2003: 34).

4.4.2 Results from field visits

The field visits in Poland took place from 9th to 12th December 2008.

4.4.2.1 Ministry of Justice, Penitentiary Department

Meeting with the Director of Penitentiary Department, and Arkadiusz Dmowski, Deputy General Director and Marek Bujak (medical director) took place.

The discussion centred around three areas

1. OST

There are 11 OST programmes in freedom and 3 in prisons:

- Remand Prison Kraków “Montelupich”
- Remand Prison Warsaw- Mokotów
- Remand Prison Warsaw – Służewiec (one more prison is in preparation at Rzeszow).

The basic problem of OST in Polish prisons is the lack of possibilities to continue the treatment after release. The number of OST patients in prison was not provided during the visit.

2. Drug Free Therapy

There are 15 drug therapy units at the time of the visit. Although these services increased over the last years there are still long waiting lists, partly even longer than before. In Warsaw prisoners have to wait for 18 months.

The length of sentence is regarded as too short for being in therapeutic institution, waiting list takes on the average throughout the country 11–12 months. Approx. 1,500–1,600 prisoners go through the therapeutic units annually. The only reason not to expand them is the lack of funds. The paradox is: three more units have been opened, but the waiting list is still the same. 2003/04 they have been increased from 10 to 15 for IDUs, and from 10 to 24 for alcohol dependent inmates. Then the length has been reduced from 12 months to 6 months (for users of illicit drugs) and from 4–5 months down to 3 months for alcohol-dependent inmates.

The reasons for the long waiting lists are:

- the change in drug law in the year 2000, which prohibits every use, which can be punished by imprisonment (critics were right who were saying this would lead to an enormous increase of drug users in prisons as well as overcrowding, HIV and hepatitis)
- also alcohol use and drink-and-drive misdemeanours was made a punishable offence which could also lead to imprisonment
- generally more penalisation, and more drug users
- police activities regarding drug users has also damaging effects in these areas

There are 24 programmes for ex-alcohol-dependent inmates lasting 3 months (mostly 12-step programmes). 30% have a dual dependence (narcotic drugs and alcohol): these prisoners are sent either to this or to that programme (in the community this programme lasts approx. 6 months).

3. Imprisonment rate per 100,000

With an imprisonment rate of 220 Poland has the 4th position in the EU. Although there is a tendency to decrease this number, overcrowding is still a big issue and the highest Polish Court has decided to strictly look after the minimum square meter per prisoner. Until December 2009 this has to be changed. The code of Execution has to be amended in future.

The solution for the problem of overcrowding is seen in the upcoming change of structures: The probation service will be developed and alternatives to

imprisonment will be elaborated. Also electronic monitoring became legal. In so far overcrowding will decrease in the near future. New prisons are being built. Old prisons need to be rebuilt.

According to the interviewees, drugs and HIV/AIDS and other BBVs are not the main health problems, not many prisoners are infected according to them. Drugs are seen as a security problem.

The main problem of Polish penitentiaries is seen in the lack of funding. The doctors have a low income and are thus hard to find for vacant jobs. These have to provide health care for a difficult clientele under difficult conditions. The budget for penitentiary institutions is rising steadily, but still funding is not sufficient. Drug treatment like all other treatments is being paid by the prisons.

For specialised care there are 13 hospitals. There are approx. 200 doctors, and approx. 1,000 doctors working part time as contracted specialists (dentists, psychiatrists etc.).

There is a co-operation with MONAR fixed in a joint agreement. MONAR has a long experience in working in prisons (>20 years).

There is no written drug strategy for prison. Drug users show up when they are intoxicated.

Foreign prisoners are not a problem, less than 1% (600 prisoners) is coming from post-soviet countries.

Doctors have a spirit of independence. Although their wage is low, doctors are in a high position in Polish society and this accounts also for prison doctors. According to the interviewees the part time doctors are forming a problem, because there is no control over their hours they are contracted for.

Both numbers of self-harm and suicide attempts are stable and low, even one of the lowest in the EU.

All medical examinations are done during the initial health screening at entrance. As major health problems are seen:

- Prevalence of hepatitis
- Probably TB, which is rising in the community.

Harm reduction policy is not being developed since the year 2000, in the opposite; condoms are not provided (any more). There is no debate about the

provision of condoms. The Polish attitude towards homosexuality needs to be understood as a background for this question.

According to studies prisoners are better informed than outside people. There is generally a low level of HIV/AIDS awareness and knowledge in the society.

Conjugal visits are possible in most prisons; it simply needs a formal agreement about who can be invited.

Sex in prisons is not seen as a big problem; rape in prisons or the existence of intimate couples are rare. Three quarters of prisoners are younger than 20 years. Male couples and homosexual activities are to be found on the lowest level in prisons. The situation for women is different. Joining in couples is mostly for safety reasons.

Tattooing is an important topic in prisons. For younger prisoners there are other forms of motivation for tattooing than in former times, where tattoos indicated sub-cultural belonging and symbols.

The drugs being used predominantly are benzodiazepines, barbiturates from the pharmacy, followed by amphetamines and marihuana. Finally the usage of strong tea is widespread.

4.4.2.2 Interview with a representative of the NGO MONAR

According to the respondent there are waiting lists for therapeutic wards of up to eight months, and there are few people who are professionals. Candidates for therapeutic wards have to wait for a long time.

Prisons don't employ many NGOs in the field of illegal drugs. This situation is different for alcohol users, where church-based institutions get into the institution.

The interviewee sees a future push for overcrowding: 30,000 people are awaiting imprisonment.

There is no written agreement between MONAR and the Prison Administration at the moment. The interviewee is employed for 1 day per week at the prison and 4 days at MONAR. Since seven years they are working in Warsaw, since 10 years in Cracow.

10–15 years ago there were no drugs in prisons. According to him prisoners start to use drugs in prison, especially marihuana and amphetamines.

The working approach of the interviewee is to create social groups, where group hierarchies can be reduced. First prisoners receive information, then they get a vision of the therapy. More or less prisoners are being prepared for the upcoming therapy. Usually they didn't have any contacts with therapy before. MONAR is providing individual and group meetings.

The most relevant health problem in prisons is the lack of doctors, they are not accessible.

Intravenous drug use in prison is perceived as being rare. First of all there are technical problems to get a syringe and a needle into the system, secondly there are subcultural constraints, which do not allow injecting drug use. There is a far bigger percentage of prisoners using and injecting drugs in the community, but they don't continue in prisons, because of social control. Although amphetamines and cocaine are being taken. Drug users have the lowest degree in the hierarchy of the prison subculture.

Sex is not a widespread problem, it is a very tabooed issue and occurs very hidden and clandestine.

The function of tattoos has changed. In the past they were used to indicate membership to certain groups or gangs, but now tattoos have a more fashionable function.

HIV is not regarded as a huge problem, the few HIV infected persons get ART treatment. Problems are perceived around the spread of hepatitis B. HBV-testing is done confidentially.

TB in general is rising in Poland, although it is not prevalent in Polish prisons yet. People are more vulnerable in prisons. Although prisoners go to the doctor, but in the community they don't go.

According to the interviewee needle exchange programmes are impossible to introduce or to even think about at the moment. The interviewee sees a lot of practical problems apart from stigmatisation of the participants in these programmes.

Substitution treatment in general is not very widespread in Poland, and so it is the case in Polish prisons.

There is no condom provision in Polish prisons. Outside in the community condoms are easily accessible in kiosks, shops, and pharmacies.

The most important reason for overcrowding is being seen in the change of the drug law in the year 2000 (see Krajewski, 2009b).

4.4.2.3 Interview with three psychologists in Slucevicsz prison

Slucevicsz is a remand prison and a prison for sentenced inmates. It holds 850 prisoners, with overcrowding 120%. In the therapeutic institution there are 36 places but 42 prisoners are in the programme. There is a waiting list for up to 2 years. The main task of the three professionals is being described as help and support for the prisoners who take drugs. For alcoholics the waiting list is increasing as well. The main reason is seen again in the changes in the law of 2000, which affected alcohol users as well.

They are working in two units:

A) Alcohol users

29 alcohol users are in the programme: two therapists and one psychologist, in total 4 professionals including one person in charge of the unit. 12-weeks-therapy is done in three parts:

- 4 weeks: working on the motivation
- 4 weeks: increase knowledge about alcohol
- 4 weeks: work on spirituality, relapse prevention etc.

First in Poland especially the programme ATLANTIS has been developed, which is perceived as similar to Polish conditions. It is very similar to the 12 steps Minnesota programme, adapted to the situation of prisoners, consisting of individual and group therapy. There is a close cooperation with AA groups in the community, who come in twice a week. The people who finish the groups go and work at AA meetings outside the prisons, to be diagnosed as “alcoholic” is a prerequisite for that. At the time of the visit there was a waiting list for this programme until February 2010 to get into the programme.

According to the interviewees there are too many sentences, too short, “half open”, and too little programmes and units for people with an alcohol disease.

B) Illegal drug users

42 people in a closed unit are diagnosed as drug addicts. The therapy is lasting 6 months, interested and suitable prisoners have to wait for one year. At the moment there are approx. 100 prisoners on the waiting list from all over Poland. In Poland there are only two units who are half open.

The programme is similar to the alcohol unit described above. There is a staff shortage in this situation: lack of 2 people, and often maternity leaves are not

substituted. Every prisoner has a personal therapist and has to take part in the group once a week.

Additionally two times a week meetings with a representative of a NGO (in this case MONAR see above) take place, plus a NA group.

The programme managers intend to integrate outside agencies (like AA, NA, and Monar), which is important after release in the sense of sustainability of the therapy success. Prisoners know where to go after release. The key intention is the provision of a continuity of care.

Most prisoners hope to get a conditional release after running through this programme. According to the interviewees at least the participation in this programme increases the chances of getting conditional release. However, prisoners expect this as a standard procedure. It is seen as hard to work with prisoners of different motivation.

The detoxification treatment is done in the hospital in Mokotov. At the time of the visit six prisoners were getting methadone, as a continuation of outside treatment.

There is no evaluation of the (sustainable) effects of the programme of therapeutic units.

The diagnosis of addiction is done by psychologists. Sometimes the drug addicted person comes by himself, sometimes there are hints in the file that prisoner are addicted.

On the basis of article 62 the court can order to go to the unit. These prisoners then have to be taken in the first row.

2007: 14 sent by court in total

2007: 73 prisoners went through the system of the therapeutic unit

2008: 88 prisoners went through the system of the therapeutic unit.

Urine tests are performed only on the basis of suspicion.

Some prisoners go back to other prisons after going through the system of the therapeutic ward, some go to pre-release units. The original intention is that all prisoners go to pre-release programmes in their respective prisons, which allows them to take part in AA/NA meetings etc.

As a critical point it was marked that the age of the prisoners is not adequately reflected.

Prisoners are sent to prison at the place they are living. The closest prison with a therapeutic unit is chosen. People cannot be in two waiting lists at the same time. When they apply then they have to confirm that they are deleted from other waiting lists (with the closest deadline).

4.4.2.4 Prisoner focus group

According to the prisoners in the focus group (9 prisoners) there is a waiting list of 2–3 years; it was the own will to participate in the therapeutic group by all of them.

The 12 step programme (NA) is seen as a useful and beneficiary programme. It teaches how to live, and is delivering orientation for living outside afterwards. They have contact groups in their villages already. The work of MONAR is regarded as being very helpful.

After running through the therapeutic units (TU) they first go back to their respective prisons without any additional programme. To stay abstinent is seen as a fiction. The members of the focus group think that they should better go on conditional release, because in their prisons they are considered as IDUs, which is stigmatising. There is no ongoing programme for them, no rehabilitation for them. So there is the risk that the positive achievements are run down again in that time in their prisons.

According to the participants intravenous drug use is very rare in prisons.

The prisoners in the focus group complain about the hygienic conditions, because doctors don't respect the hygienic needs of prisoners, e.g. the dentist does not change the gloves and they mistrust the hygiene standards of the instruments they use. They fear getting infected by the dentist.

Once a week there is a doctor in the prison where they can get medicines. They fear that this is one pill/therapeutic for all diseases (Paracetamol[®]) no matter which disease the prisoners have (stomach pain, head ache etc.).

Sexual contacts among prisoners are very rare as well. Tattoos are done with boiled needles, with the prisoner's own needles. But it remains a punishable behaviour.

The suggestions of the focus group members for the medical health system are to have more doctors, and other specialists. More respect for prisoner's needs is demanded. The health care services in Mokotov prison are supposed to be good.

According to the focus group members OST should be introduced. Also needle exchange programmes should be introduced although it is seen as very hard to exchange needles anonymously.

Also therapy instead of punishment is seen as an important strategy and should be introduced. Almost no prisoner of this group receives pre-release treatment or conditional release.

After the treatment they go back in different prisons in the regions with no conditional release, which leads to a loss of motivation for the treatment programme. Prisoners complain that they serve sentences for relatively small offences.

4.4.2.5 Interview with a prison doctor

The prison employs one full doctor, two part time doctors, in total the medical doctors cover a 1,25 post together.

According to the interviewee key health care services are available in Mokotov prison: Surgery, internist, infectionist, psychiatrist, radiologist etc., mostly part time. The HIV/AIDS specialist resigned recently.

The most frequent health problems are seen in the fact that prisoners are not interested in health services. According to the interviewee they are not interested in getting healthy, but to have some arguments with the doctors. According to the doctor their medical sense is insufficient.

The reason for the lack of doctors is the fact that they are not paid enough.

15–20% of the prisoners are supposed to be in contact with drugs, either dealers and/or users themselves. Dependencies of different drugs: every 3rd prisoner is supposed to be an alcoholic. 10–15% of the whole prison population are chronic alcohol users.

In the first three days the prisoner comes and is examined and investigated. HIV tests are done on the basis of informed consent, prisoners are ticking the box in the form and additionally write it down. An HIV test can also be suggested when there are visible signs. There are financial problems in offering HIV testing. So testing is not offered very actively to prisoners. The hepatitis test is also voluntary and is performed on suspect.

With regard to the situation of HIV-positive persons there are 4 HIV-positive prisoners, from whom two patients receive an ART treatment.

25–40 prisoners take an HIV test per year. There is a dark figure of HIV-positive patients. 60 persons know that they are HCV-positive. An HCV test is taken by 50 prisoners per year: 10–15% is HCV-positive – very huge dark number also in the society. The knowledge is lower regarding HCV than with respect to HIV. According to the interviewee problems arise also from tattoo sales.

According to the doctor there is very little sexual (risk) activity going on in prisons. Tattoos and other harms are seen as more risky: using the same razors, scissors etc. The fashion of tattooing is increasing among prisoners but hard to detect. Guards are wearing gloves when searching.

Many health care programmes are not perceived as such by prisoners – this is a basic difficulty.

Every prisoner is x-rayed. Less than 1% refuse the screening. TB is a rising issue in prison and in the Polish society at large. A few people per year need treatment. TB treatment in prison is very effective (for 6 months). It has a high level of adherence compared to the outside.

With regard to health care delivery the strengths are: competent doctors and nurses, specialists, very quick access to a specialist compared to the outside. But this is still not satisfying. The weakness of the system is the ethical problem of the fact that inside people wait one week, outside they wait 6 months for a treatment or adequate health care.

The interviewee describes a contradiction: prisoners state they want to get cured, but only a low percentage really wants to be cured and adheres to what the medical advices were. When being released they don't continue to take the medicine. That means inside prisons the demands are rising and are leading to irritations and injustices.

4.4.2.6 Mokotov hospital

It is the biggest hospital in the Polish prison system and forms the central service for the whole Warsaw region and for the North-East of Poland. The hospital carries out consultancies for other Polish prisons. At the time of the visit there were nine hospitals in Poland, they have a 24 hour emergency service.

Organisationally the respective prisons are paying for every patient brought in. There is also a certain budget to use beds in public hospitals.

Some services for drug users are: Since April 2004 there were 34 people in OST in Polish prisons. In Warsaw were 30 of them, six in Mokotow prison hospital. The following prisons belong to the Warsaw region:

- Mokotow
- Sluseievic
- Bialowenka
- Siedlce.

OST is also offered in the Montelupich prison in Krakow (seven patients at the moment). OST treatments are only continued from outside – with very strict rules.

The three most prevalent diseases in four wards are:

- Surgery (gallbladder, warts, problems of blood circulation)
- psychiatry (for observation)
- orthopedia
- internal medicine.

With regard to HIV/HCV, and HBV patients have to agree to the test and treatment, HIV test doesn't have to be paid by the inmate.

The prison hospital is cooperating with other hospitals, when there is a lack of devices or competence of diagnosis and treatment (e.g. no computer tomography). HCV treatment is carried out only in one prison for the whole of Poland (Potulice).

What should be changed?

- lack of money is a huge problem,
- doctors and staff shortages.

The hospital does not fulfil EU-requirements, which according to the law and EU demands have to be fulfilled in 2010. The hospital only has few technical means. A new hospital should be build, but there remain practical problems.

Interview with prison governor and chief of educational / therapeutic programme

The building of the prison in Lubliniec was erected in 1892, since 1960 it serves as a women prison. They have only a few two bed cells, more often there are 6–12 beds per cell. 60% of the staff is female, males are mainly in

specialised staff (psychologists) etc. There are three psychologists in the therapy unit.

The prisons hosts 227 female prisoners, remand, closed, half open, and closed. At the time of the visit there are 266 prisoners, figures went up to even 305 in the past. There are no foreign prisoners at the time of the visit. 50% of all females prisoners have children. There are also two other prisons for women in Gendziadz and Krzywaniac. Lubliniec is not the biggest prison, but it is running a therapeutic programme for drug users.

Very few drugs are confiscated in the institution. Sometimes the drug dog from Bitom is led through the prison. There are a lot of restrictions (regarding hygienic means and creams etc.), which are not allowed to be brought in. Drugs are being brought into the prison to a low degree. Family members and guests are checked. Parcels and visits are checked thoroughly. The following provision is being made: one parcel four times a year, approx. once a month; given as a reward, parcels for food and for clothes and hygienic means – a lot of controls are happening. Parcels with clothes can be received permanently.

Regarding visits as a closed type of prison there are two visits in one month. One visit is lasting for an hour. The half open regime allows three visits for one hour for one month. Receiving visits can also be subject of awards. Or visits can be prolonged. Prisoners are not visited very often. The relatives, husbands etc. have to come from all over Poland. Drug addicts in the closed unit of the prison are being visited two times per month.

Long-term visit is possible as a normal visit or as an award. This is not applicable for intravenous drug users because of suspected problems of drug transfer.

The key health problems of prisoners are seen in the fact that they are not treated before, and they hope to be cured and solved all problems in the institution. An addiction to drugs and alcohol is widespread in the institution. There are supposed to be 100 drug addicts and 160 alcohol addicts.

There are several conferences and vocational trainings for directors and for psychologists during the year. There are three work programmes: with women with children, schizophrenic and older people. It depends on what kind of crime has been committed, there are 20–25 prisoners per year.

With regard to outside agencies the AA group comes in every month. An AA group also exists in the prison itself, which meets on a weekly basis. 40 alcoholics are living together with a partner who is also alcoholic. The medical

unit is formed by five nurses (full employment), plus two nurses as a civil agreement.

According to the governor the medical health care is good. There are some specialists but not all, in cooperation with outside hospitals. The prison has a rising budget for health care.

The drug addiction unit is very similar to the one in Slujevecz. Even the week plan is quite similar: 2 therapeutic groups from 9–11, at 12 education courses, 13:00 lunch, 2 hours of open cells where prisoners can meet each other, 1 hour yard exercise. On Monday the doctor comes into the prison.

After being sent back to their original prison, prisoners can apply for conditional release, the numbers of applications are not filed. They all go back to the pre-release unit in their respective prisons.

Professionals write recommendations of what to do afterwards for their prison colleagues, but they don't know if colleagues in the prisons follow these recommendations.

HIV-positive prisoners receive an intensive care which is not given in the prisons where the prisoners originally come from. According to the interviewees there is a high level of confidentiality applied in the prison medical unit.

The prison also cooperates with MONAR (in Chestonova), and prisoners can attend the meetings of AA in the prison.

Many prisoners suffer from a dual addiction (from legal and illegal drugs). The governor and the senior of psychologist think that the therapeutic unit is very effective.

Very little drug use is recorded; very rarely benzodiazepines are prescribed. Urine tests are being performed once a year, but only heroin smokers users are detected.

Relationships do occur in the prisons; but couples are being separated because they don't take part in programmes.

Focus group

According to the members of the focus group (10 female prisoners), the strengths of the therapeutic unit are:

- living conditions are better
- 2 hours therapy sometimes even less
- All but one of them were forced to undergo treatment by court decision
- Hope to get conditional release
- No treatment here
- People should go to the therapeutic units outside, but this is not possible.
- They are prepared for treatment outside

The weaknesses are:

- Limited contacts with family and friends (from all over Poland)
- Reduced lists of visitors
- List of visitors has to be agreed (if the family does not agree or there is no family, then there is no visit)
- Very limited access to outside agencies (only Monar which is trying to transfer to MONAR outside)

The question if the stay in the therapeutic unit was worth it the interviewees said that they expected to get conditional release after completion of the therapeutic unit. But according to experiences once back in their prisons they are treated like normal prisoners.

According to the participants OST should be introduced in the prison, at least for detoxification purposes. Two of them already had experiences with OST. No medications are available except Paracetamol®.

According to the respondents the prisoners do not receive the requested and needed proper medicines of equivalence. Furthermore the waiting list is very long.

The situation by the participants of the focus group are described as follows:

- Less vitamins than outside,
- painkillers are not provided,
- Several of the respondents applied for a HIV-test, and didn't get it (in one case for four months)
- In Warsaw there is a specialised nurse in a normal prison, no HIV tests are offered.
- No education of HIV/AIDS is given in the prison.

Prisoners feel isolated, now the cell doors are mainly closed. This is different to the situation in 2003, when the doors were open. This has been changed after the treatment of a prisoner who killed her child. Some of the respondents go to the sessions MONAR is offering, some stay in the penitentiary.

According to the participants there is no confidentiality in the prison. They unanimously fear to relapse after release.

The prisoners complain about the “illogical treatment concept”: which was criticised as follows: “you can’t open up, because confidentiality is not guaranteed, so we don’t trust each other. It would be better to talk to NGOs or other people who take drugs, than to speak with employees (though psychologists) of the institution”. All of the respondents said that it would be better to offer therapy in the community.

Most of the participants feel bored about the almost repeating structure of the therapy sessions:

- “Describe the film”
- “Describe the victim”,
- “Describe the feelings after the film”

Furthermore they complain about the absence of an age specific therapeutic approach.

Interview with a nurse

She is responsible for the whole prison health care delivery. HIV-tests are carried out on the basis of informed consent (like in Slusewiecz). There are neither HIV statistics of already infected prisoners, nor HCV prevalence or incidence data available.

Three main diseases are described:

- Skin diseases
- HIV
- TB – supervision

Self harm is an issue in the prison during the whole sentence and not only in the first weeks. Tattoos do no longer form a health problem like in the 90s. There are several co-operations with other agencies in the community and region. Due to a lack of money there is no HCV treatment available.

According to the nurse more medical specialists are needed. Regarding the drug therapy unit the group therapy is seen as an important tool. Also the MONAR staff is seen as very important – partly because they are drug addicts themselves.

4.4.3 Results from inmates' survey

In Poland the survey was conducted in four prisons (for detailed description see chapter 2.5). 114 inmates answered the questionnaire. They divide onto four prisons as follows: 26.3% from the Lubliniec women prison, 16.7% from Warsaw (Recidivists prison), 26.3% from Rzeszow (Recidivists prison), and 30.7% from Wroclaw (first-time sentenced).

All respondents are on therapeutic units in prisons; therefore all of them have a history of problematic drug or alcohol use, thus representing a highly selective group.

4.4.3.1 Description of the sample

A quarter of the sample is female (26.3%). The mean age (N=109) is at 27.8 years (SD 5.3), ranging from 20–45 years. There are no differences for the age between men (mean age 27.7 years) and women (28.0 years). The majority speaks Polish as mother tongue, only one respondent speaks Lithuanian.

The education level is shown in table 35. The school system in Poland has changed in 1999 as follows: The primary school lasts for 7 years. Then comes an intermediate level of education (in Polish “gimnazjum”) of 3 years. Both levels are mandatory. After “gimnazjum” come again 3 years of “lyceum”, and “lyceum” ends with maturity examination or Abitur. This is not a mandatory education. There are also various types of more vocationally profiled schools of “lyceum” level which end with maturity examination. But there are also purely vocational schools, without maturity examination (they may be entered also by those who finished “gimnazjum”). Only those with maturity examination may enter the university, which is the highest educational level. The difference with the earlier system is that there were no “gimnazjums”, only primary schools (8 years), and “lyceums” (4 years). In the old situation you could treat “lyceum” as an equivalent of high school or similar. Now, things get more complicated, as there is intermediate level between primary schools and high schools (“liceums”), namely “gimnazjum”.

Some respondents have been educated with the old school system and some with the new. This has to be considered when looking at the results in table 35.

Table 35 Level of education, Poland (N=113,%)

	total	men	women
primary school	38.1	41.0	30.0
uncompleted primary school	4.4	2.4	10.0
Gymnazjalne (intermediate school)	10.6	7.2	20.0
uncompleted Gymnazjalne	0.9	0	3.3
lyceum	15.0	16.9	10.0
uncompleted lyceum	2.7	2.4	3.3
vocational	25.7	26.5	23.3
university	0.9	1.2	0
uncompleted university	1.8	2.4	0

More than three quarters of the respondents are single (see table 36) with no big differences between men and women.

Table 36 Marital status, Poland (%)

	total	men	women
single	78.1	77.4	80.0
married	8.8	7.1	13.3
having a partner	8.8	9.5	6.7
divorced	4.4	6.0	0
widowed	0	0	0

33.7% of the sample do have children (N=95), less men with 30.6% than women with 43.5%. Range lies between 1 and 9 children, the mean number of children is 1.7 (SD 1.5), for men 1.4 children (SD 0.6), for women 2.3 children (SD 2.5).

4.4.3.2 Imprisonment

The prison sentence of the respondents is on average rather long, the majority was convicted for more than five years. Men and women differ significantly concerning the length of their current prison sentence ($p < 0.000$). Men got much longer sentences, over half of them are convicted for more than five years, only 6.2% of men serving less than a year while the majority of women was sentenced to 1–3 years, and 17.2% to less than a year.

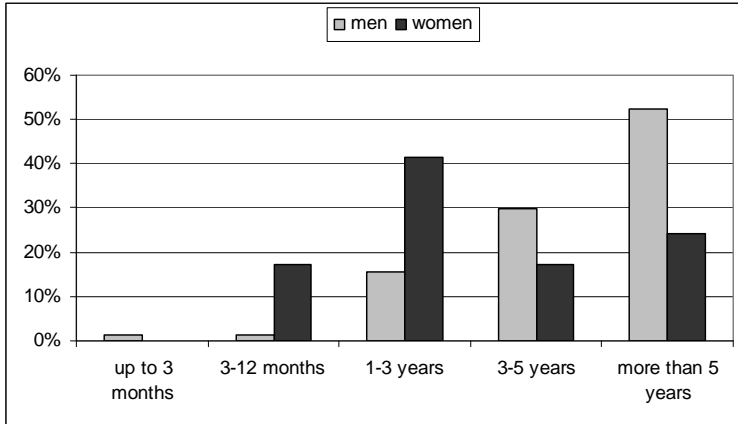


Fig. 36 Length of current prison sentence, Poland (N=113)

Looking at the time of prison stay served until the survey (see table 37), it becomes clear that almost half of the respondents has been in prison for more than a year, and another third already more than three years. Again, women experienced far shorter time in prison than the men, this is statistically significant ($p < 0.000$).

Table 37 Stay in prison on this sentence until now, Poland (N=106)

	total	men	women
3 months or less	2.8	1.3	7.1
3–12 months	17.0	5.1	50.0
1–3 years	47.2	52.6	32.1
more than 3 years	33.0	41.0	10.7

A similar picture occurs when looking at the cumulated time in prison during the last ten years. Women have spent shorter time in prison than the men ($p < 0.000$).

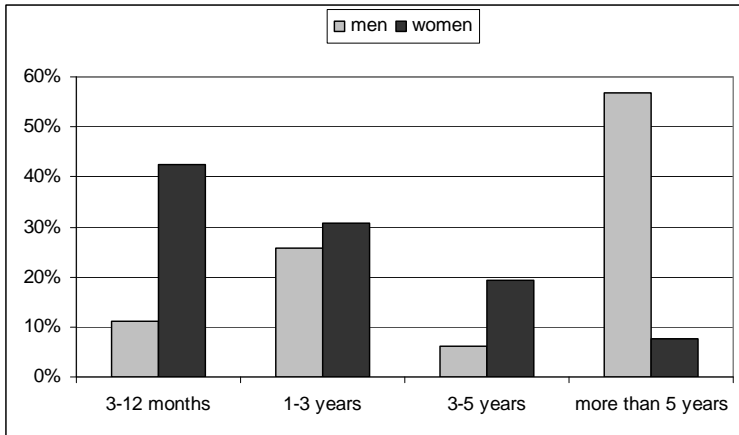


Fig. 37 Prison time in the last ten years together, Poland (N=107)

On average the respondents served 2.2 (SD 1.5) different sentences during the last ten years (N=98), the median being two times, and ranging between 0 and 8 times. Men served slightly less different sentences with 2.2 times on average (SD 1.4), and women 2.4 different sentences (SD 1.8).

The prisoners were asked to state the circumstances in prison they are most suffering from (see figure 38, multiple answers). The prison restrictions were rated as the most difficult item, followed by boredom and feelings of loneliness. Women suffer significantly (p -value < 0.05) more from a lack of professional support, the separation from their children, and a drug or alcohol problem than men.

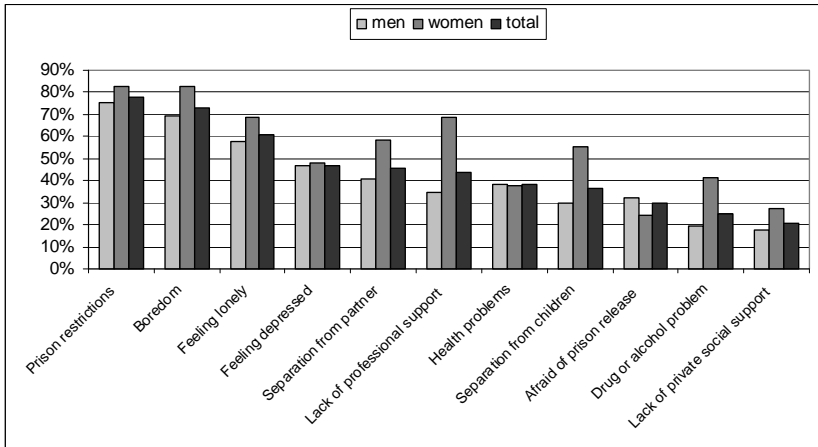


Fig. 38 Suffering in prison situation, Poland (N=107, %)

4.4.3.3 Health

The respondents were asked to rate their own health status, both physical and mental health (see figure 39). Most remarkable is that generally the physical health (57.9% good or very good) was rated much better than the mental health (44.5% good or very good). Women rate their health, both physical and mental health, worse than the men do.

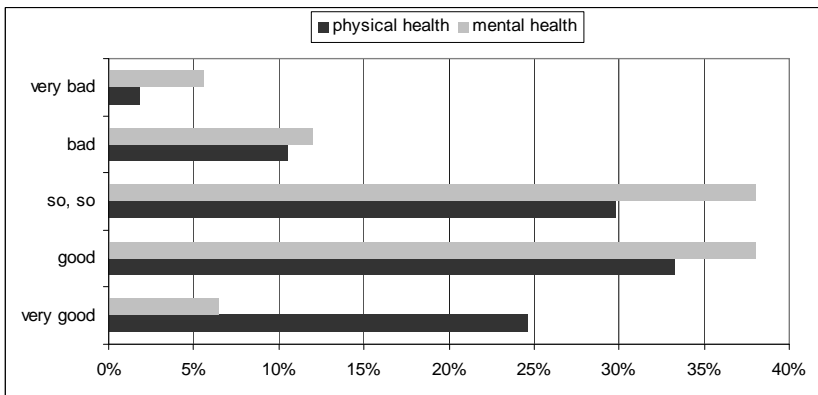


Fig. 39 Rating of own health status, Poland (%)

The proportion of inmates with HIV infections is 9%, the interviewed women being infected much more often with almost a fifth of the women (19.2%, men 5.4%). The willingness of the respondents to answer these delicate questions on their infectious status was high, only few refused to answer these questions (4% for HIV and 1.9% for HCV).

For hepatitis C infection the picture looks similar (see figure 40). Women report to a greater degree an infection with hepatitis C (34.5%) than men (19.2%), while for hepatitis B the picture is similar for both on a very low level.

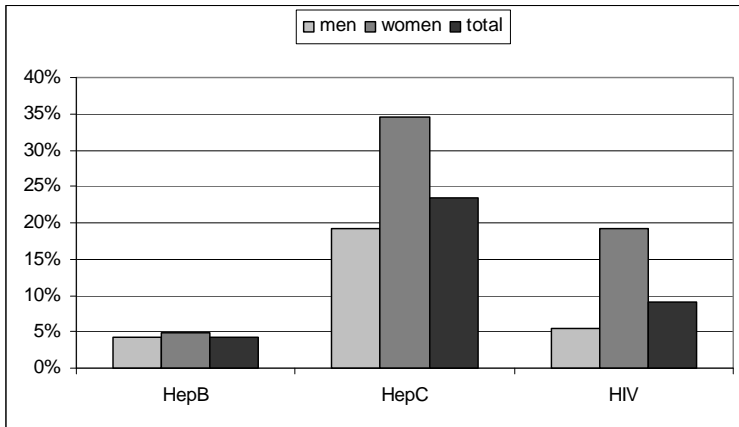


Fig. 40 Infection rates, Poland (%)

Only few of those with HIV or HCV infection report to get antiretroviral treatment for HIV (n=3) or HCV retroviral treatment (n=1), but response rate to this question was low.

Tuberculosis is only reported by 1.1% of the sample (N=89), and 3.4% each stating not to know or not wanting to answer this question. The one person infected is a woman.

For the past 30 days a number of diseases and symptoms are reported (see table 38). The most prevalent are sleep disturbances and depressions. More men than women report to have no health problems.

Table 38 Diseases in the last 30 days, Poland (N=101, in%)

	total	men	women
Sleep disturbances	53.5	55.4	48.1
Depression	35.6	32.4	44.4
Respiratory problems	17.8	17.6	18.5
Hepatitis A	3.0	1.4	7.4
Drug-related overdose	3.0	1.4	3.7
Sexually transmitted infections	1.0	0	3.7
Epileptic fits	1.0	0	3.7
other	5.9	5.4	7.4
no health or psychological problems	35.6	39.2	25.9

4.4.3.4 Drug Use

94.6% of the sample state, they are (or were) drug user (N=112), all of the women and 92.9% of the men. As the survey was done in drug-free units this could be expected. Estimating the drug use in the prison by the inmates serves as an indicator of the prevalence of prison drug use. Although the inmates' estimations range from 0–100% for all different substances, some differences can be seen when looking at the average estimations. Even if the numbers don't give a precise picture they can serve as an indicator for the differences between substances. Cannabis and amphetamines are clearly leading, which is in line with other research, that these are the most commonly used drugs. Around half the respondents state not to be able to estimate the prison drug use.

Table 39 Estimations on Drug use in prison, Poland

	Mean	Range	Don't know (% of all N=114)
Cannabis (N=38)	50.4	0–100	45.6
Alcohol (N=29)	25.9	0–100	49.1
Heroin/Opiates (N= 31)	20.8	0–100	50.9
Kompot (N= 27)	16.9	0–100	53.5
Cocaine (N=27)	17.2	0–100	54.4
Crack/Freebase (N=25)	11.9	0–100	54.4
Amphetamines (N=39)	49.4	0–100	49.1
Methadone/buprenorphine (N=19)	7.4	0–100	57.9
Benzodiazepines (N=17)	17.1	0–99	57.0
Ecstasy (N= 29)	28.3	0–100	62.6

Apart from tobacco and alcohol outside prison the most commonly used substances are amphetamines and cannabis, with a life-time prevalence of almost three quarters each (see figure 41). Almost the same is true for the drug use inside prison, where apart from tobacco again amphetamines and cannabis are the most common substances. Alcohol is not used that much in prison and all substances with the exception of tobacco (the only legal substance in prison) are used inside far less than outside prison. So drug use inside is reduced, but it does take place.

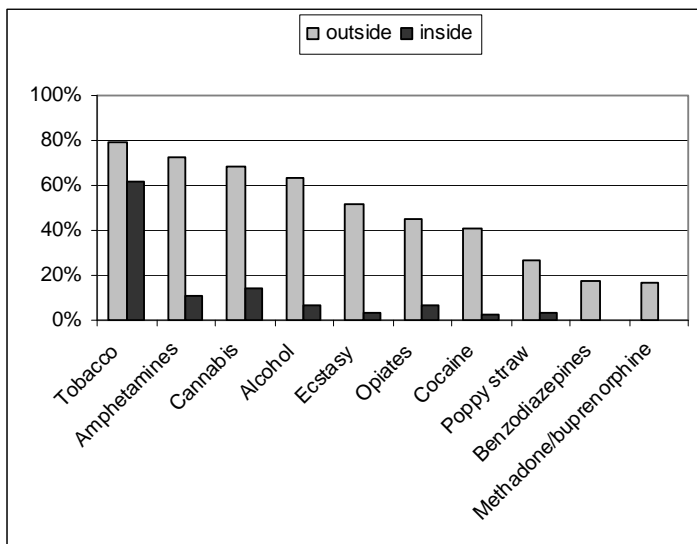


Fig. 41 Own Substance use, Poland (% of all)

The analysis revealed that more men have experience with cannabis, alcohol, cocaine and crack cocaine, while a greater proportion of the women did ever use opiates and kompot. Looking at the drug use inside prison, it can be seen that more women than men use opiates and amphetamines, while more men use cannabis in prison. For the other substances differences are marginal and can be due to the low response rate.

Only very few (between 1 and 7 persons for each substance, only for tobacco it was n=26) answered the question on how many days they used the different substances, so this item could not be evaluated.

The preferred route of administration varies for the different substances. Injecting drug use is practiced by one quarter of heroin users and by three quarters of kompot users. Also amphetamines (one quarter) and benzodiazepines (one third) are injected rather frequently. As the number of answers is small, no gender specific calculations can be done for the route of administration.

The acquisition of drugs in prison generally is perceived by half the sample as easy or very easy, whereas the other half rates it as rather difficult or very

difficult (see figure 42). Women rate the acquisition slightly more difficult than the men.

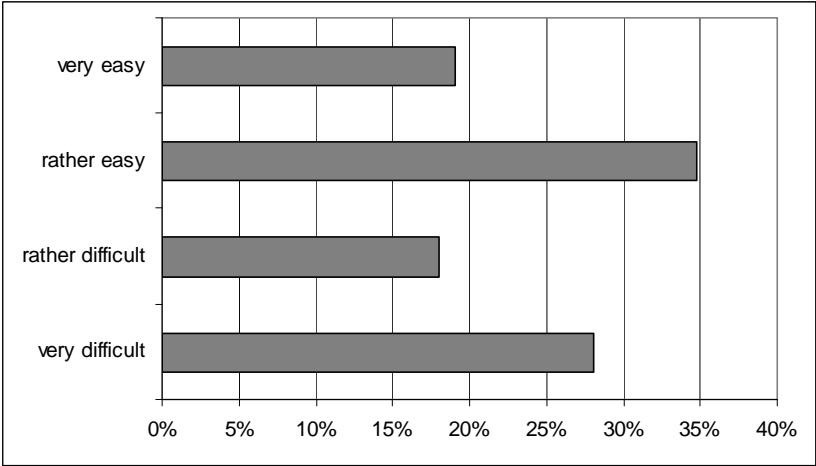


Fig. 42 Acquisition of drugs in prison, Poland (N=89, in%)

4.4.3.5 Risk behaviour

Sharing of syringes and injecting equipment does not seem to take place to a high degree in the Polish prisons included in this study. The interviewees report less syringe or equipment sharing inside prison than outside. This might be due to less injecting behaviour in penal institutions, which could not be assessed for the Polish sample.

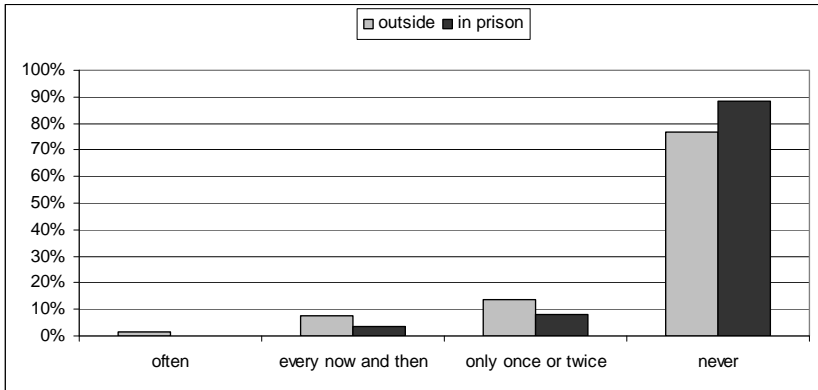


Fig. 43 Syringe or equipment sharing, Poland (%)

Violence does take place in prisons. 14.4% of the inmates report that sexual violence does take place, while physical and psychological violence exists more often, which about half the sample reports (see figure 44). There are no differences between men and women concerning the different forms of violence. The only difference can be seen at the denial and knowledge of sexual violence: The majority of men state not to know about sexual violence while the women state more often that it is non-existing.

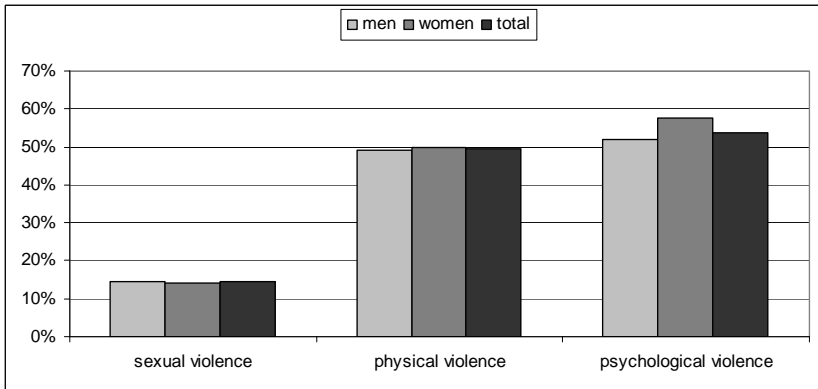


Fig. 44 Estimation on violence, Poland (%)

Only few respondents estimated the presence of sexual contacts and especially when force or violence was included, while the majority states not to know about it.

Risk behaviour occurs to great extends in the prisons (see figure 45). Tattoos made in prison are more prominent among the men, while women have more piercings made, for both the difference is not significant. The only significant difference occurs for sexual contacts in prison, with significantly more women reporting sexual contacts than men. There is an obvious reluctance among the men to talk about sex in prison (which means men having sex with men). This also became clear, when conducting the survey; some of the men were laughing about the questions concerning sex and denying the existence of any sexual contacts in prison, while the women talked freely about their (homosexual) relationships in prison. This is confirmed by other research in Polish prisons (MacDonald, 2003: 26f.). Tattoos and piercings made in prisons are reported by more than two third of the prisoners.

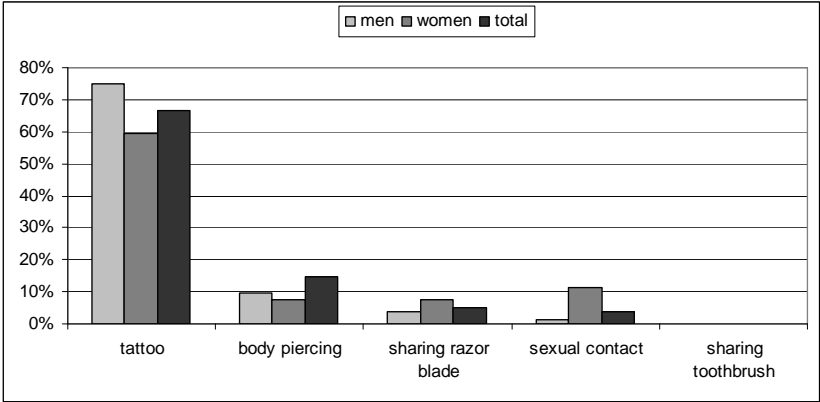


Fig. 45 Other risk behaviour, Poland (%)

17.5% of the sample (N=103) report conjugal visits, 20.5% of the men and only 8% of the women. Some remarks on desired changes in prison concern conjugal visits (see chapter 4.4.3.6: treatment needs), although according to the law conjugal visits are possible.

4.4.3.6 Help Services

Although substitution treatment is possible in Polish penitentiary system, it is not offered frequently (see chapter 4.4.1.4). Of the sample only n=5 respondents are currently in substitution treatment.

Some of the answers have to be regarded cautiously, as inmates did not always understand the different kind of treatment. Especially substitution maintenance treatment, short-term abstinence intervention, psychosocial support, low-threshold facilities, and needle/syringe exchange wasn't always understood.

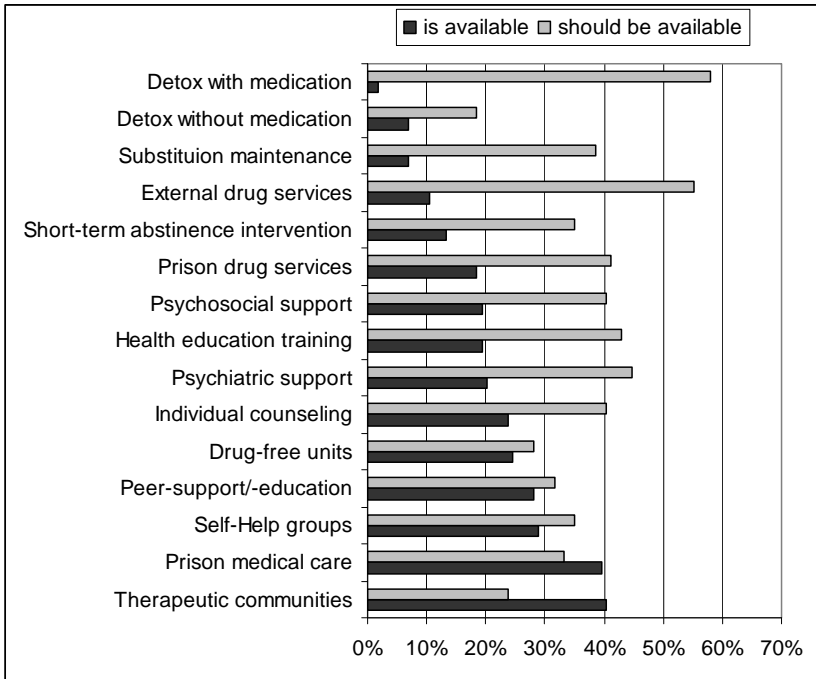


Fig. 46 Availability of help services in prison, Poland (% of all)

There are some additional issues mentioned that should be available: better medical care, conversation with psychologist, to change the therapist to therapist from the community.

Inmates do use several services in prison (see figure 47). As the answers for each question were rather few, no gender-specific evaluation was possible. Some items were not understood or maybe confounded with community services, as e.g. needle exchange is not available in prison, but a few reporting to utilize it.

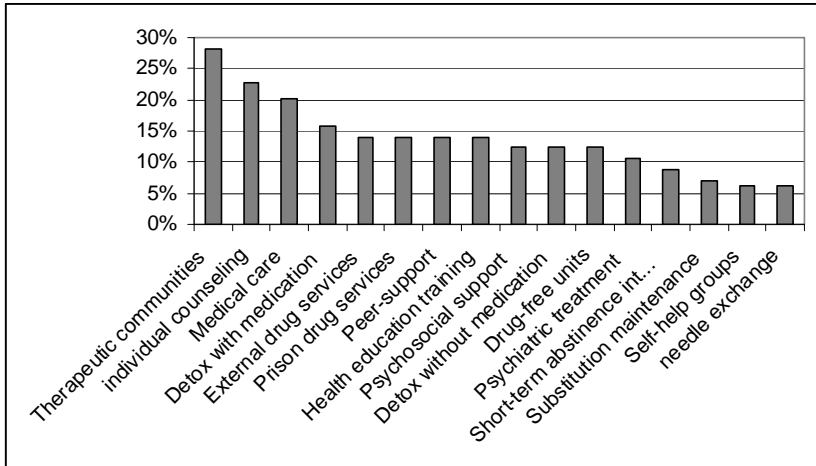


Fig. 47 Services used in prison, Poland (% of all)

Comparing the service use inside and outside prison, not many differences can be observed. Some services are specific to either prison or community, but despite these differences, the utilization of drug help services doesn't show great differences. Some inmates did have difficulties to differentiate the categories of the questions, e.g. if the service was applied inside prison or in the community.

Further remarks on which other services they find important can be divided into two groups: General wishes concerning the prison restrictions, and those requests about health care. The answers are divided for men and women, as can be seen in tables 40 and 41.

Table 40 Service needs of men, Poland

Concerning health care	Concerning prison generally
Better health care (6x)	sport, gym (5x)
psychiatric treatment (2x)	good food, nutrients (3x)
self-help groups (2x)	to respect the hygiene, cosmetic care, showers (3x)
good dentist (2x)	assistance for prison release (3x)
drug-free units	better TV, repair TV (2x)
AA, NA	Internet (2x)
conditions are not good, therapists don't care	intimate visits (2x)
health care outside the prison	contacts with girls
individual counselling	more learning
internist	more bearing prison rooms
longer therapy	more time and place to walk
professional treatment, specialists	prostitutes
support to treat addiction	social service
	solarium

Women mention a lot more health-related issues, while men also emphasize the need for sport possibilities and generally leisure time activities. One male inmate stated that he would not ask for medicine because prison staff might meet this negatively and ban him from attending the gym.

Also during the conduction of the survey, the inmates complained about the medical service in prison, the lack of medicine available and being given the same medicine for every ailment. The amount of food was another issue mentioned during the survey, which might have implications on the health as well. Similarly the frequency of showers and the lack of sport and/or fresh air were mentioned. Others reported about correspondence with authorities being censored, despite not being legal. This leads to the situation that inmates do not write complaints anymore to the authorities like court or attorney.

Table 41 Service needs of women, Poland

Concerning health care	Concerning prison generally
better health care (5x)	better living conditions (3x)
substitution treatment (2x)	more contact with family (2x)
24h medical support	better understanding
a real group therapy	better access to store room
detoxification	better leadership in active aims
individual psychological support not connected with addiction	
methadone	
psychiatric treatment	
real psychological help	
to receive medicines	

Less than a third of the respondents (29.9%) state the existence of a treatment plan, and one third doesn't know about it although the majority with two thirds has applied for a treatment plan. Women know significantly less often about a treatment plan (13.0%). Also assistance for prison release is not existent for more than half of the respondents.

The quality of treatment is assessed rather badly by the inmates with more than half of the respondents rating it rather bad (see figure 48). There are no significant differences between the men and the women.

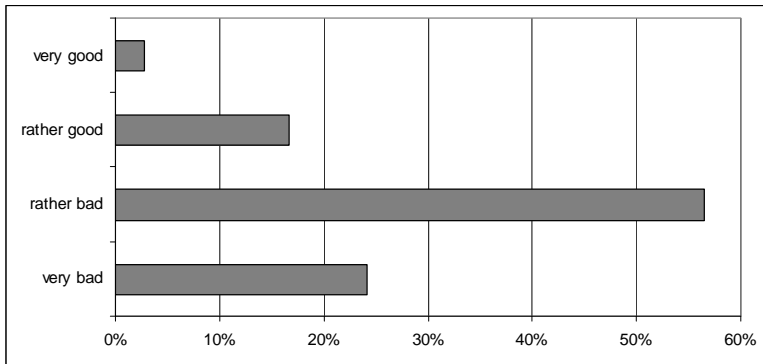


Fig. 48 Assessment of the quality of treatment, Poland (N=108)

4.4.4 Conclusions

The prison population rate in Polish prisons is 220 prisoners per 100,000 inhabitants, which means that Poland holds the 4th position in the EU. Although there is a tendency to decrease this number of prisoners, overcrowding is still a big issue.

Life time prevalence of different drugs is high among Polish prisoners, with marijuana and amphetamines being the most popular drugs. A study reported injecting drug use by 6.7% of the respondents. This is in line with results from our study: 7% of the prisoners reported having used opiates ever in prison, 3.5% kompot. It can be seen that more women than men use opiates and amphetamines, while more men use cannabis in prison. Injecting drug use is practiced by one quarter of the heroin users and by three quarters of the kompot users. Also amphetamines (one quarter) and benzodiazepines (one third) are injected rather frequently. This epidemiological picture is confirmed by several experts interviewed: intravenous drug use in prison is perceived as being quite rare.

The proportion of inmates with HIV infections is at 9%, the interviewed women being infected much more often with almost a fifth of the women (19.2%, men 5.4%). For hepatitis C infection the picture looks similar. Women report to a greater degree an infection with hepatitis C (34.5%) than men (19.2%). Women seem to be an extremely vulnerable group.

Risk behaviour occurs to a great extent in Polish prisons. Tattoos made in prisons are more prominent among the men, while women have more often piercings made, for both the difference is not significant. Tattoos and piercings made in prisons are reported by more than two third of the prisoners.

Regarding sexual contacts in prison significantly more women report sexual contacts than men. There is an obvious reluctance among the men to talk about sex in prison.

There were 15 drug therapy units at the time of the visit. Although these services increased over the last years there are still long waiting lists, partly even longer than before. In Warsaw for instance prisoners have to wait for 18 months.

Although prisoners listed a lot of advantages living in therapeutic units, critic was expressed on the problem of lack of confidentiality when disclosing secrets or very personal information. Therapy within the closed setting of a prison necessarily leads to problems of mistrust, gossips etc. External and not

prison employees should offer this kind of psychological treatments. Furthermore prisoners expressed their disappointment regarding getting conditional release after completion of therapeutic ward. But according to experiences once back in their prisons there are treated like all other prisoners.

Regarding OST in Polish prisons there is a lack of possibilities to continue the treatment after release, because the number of places in OST programmes is limited and not available in all parts of the country. This leads to the fact that only a very small number of prisoners receive this treatment.

Harm reduction policies for prisoners are not much developed. Condoms are not provided, there is even no debate about the provision of condoms or other harm reduction material for drug users (e.g. clean needles and syringes).

Every seventh prisoner reports sexual violence taking place, while about half the sample reports physical and psychological violence.

4.5 Summary of the quantitative results from all four countries

In total 490 inmates were asked by self-completed questionnaires, which divide on the four countries as follows: Estonia 167, Hungary 102, Lithuania 107, Poland 114. 64.1% of the sample are men (N=314). Women (N=176) are 35.9% of the sample. The age ranges from 19 to 67 (N=473) with a mean of 30.9 years. Men have a mean age of 30.2 years, women have a mean age of 32.1 years. The level of education varies and is difficult to compare between countries, but generally speaking the proportion with higher education is small over the whole sample (university 2.5%, specialized school/ college 12.1%).

In all four countries the majority of inmates is serving long and very long sentences with more than three years (61.1%) and only few serving less than a year. The proportion of long-term sentences is highest in Poland and Hungary (see figure 49). Of the whole sample 56.3% have been in prison more than three years during the last ten years (partly on multiple sentences).

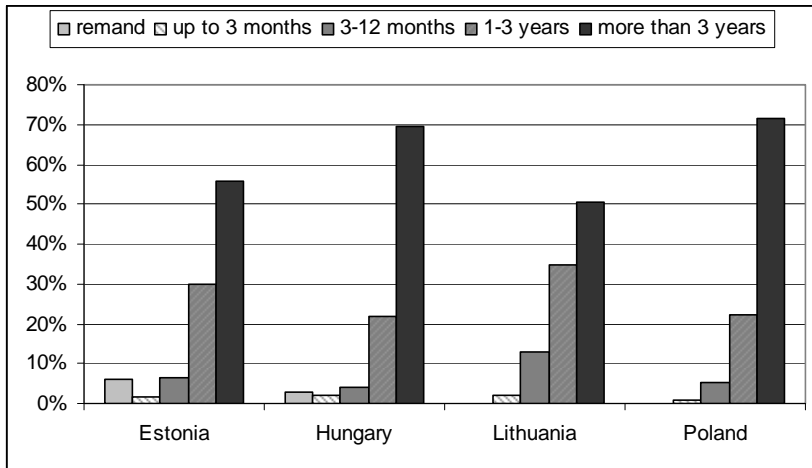


Fig. 49 Length of sentence, four countries

The most problematic circumstances of imprisonment perceived by the sample can be seen in table 42 below.

Table 42 The most problematic circumstances

	women (N=175)	men (N=301)	total (N=476)
Prison restrictions	62.3%	69.1%	66.6%
Boredom	44.0%	51.8%	48.9%
Separation from partner	40.0%	53.8%*	48.7%
Feeling lonely	46.3%	46.8%	46.6%
Separation from children	58.9%	38.5%**	46.0%
Feeling depressed	45.7%	42.5%	43.7%
Health problems	33.7%	32.2%	32.8%
Lack of private social support	26.3%	32.9%	30.5%
Lack of professional support	28.6%	23.6%	25.4%
Afraid of prison release	24.6%	24.6%	24.6%
Drug or alcohol problem	16.0%	13.0%	14.1%

*p=0.004 **p=0.000

18.7% of the whole sample report a HIV infection and 32.2% a HCV infection. The prevalence of infectious diseases varies greatly between countries. While in Hungary almost nobody reported an infection with HIV or HCV, the proportion in the other three countries is up to 50% for HCV and 40% for HIV (see figure 50).

The physical health was rated by the inmates better (52.8% very or good) than the mental health (42.4% very good or good). Men do rate their own health better (56.6% very good or good for physical health and 45.9% for mental health). Women rate their physical health with 46% very good or good, and their mental health 36.3% very good or good.

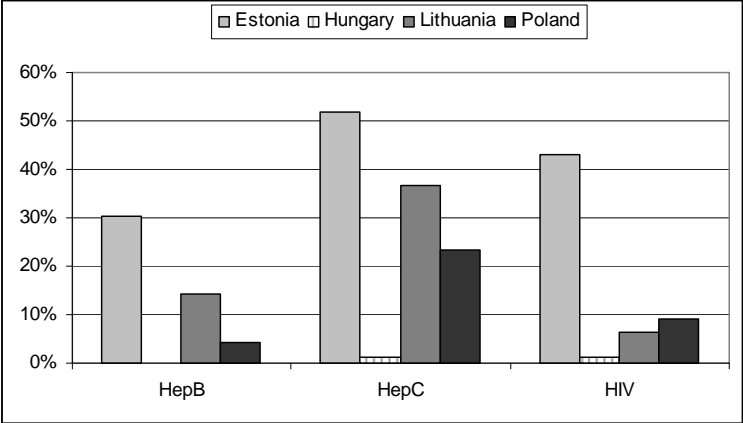


Fig. 50 Status of infection, all four countries

The drug use experiences both inside and outside prison vary between the four countries enormously. Tobacco is the most commonly used substance, and the only legal one in prison. 67% of the women and 66% of the men report tobacco smoking in prison. For most substances the lifetime prevalence is lowest among the Hungarian sample and highest among the Estonian and Polish sample.

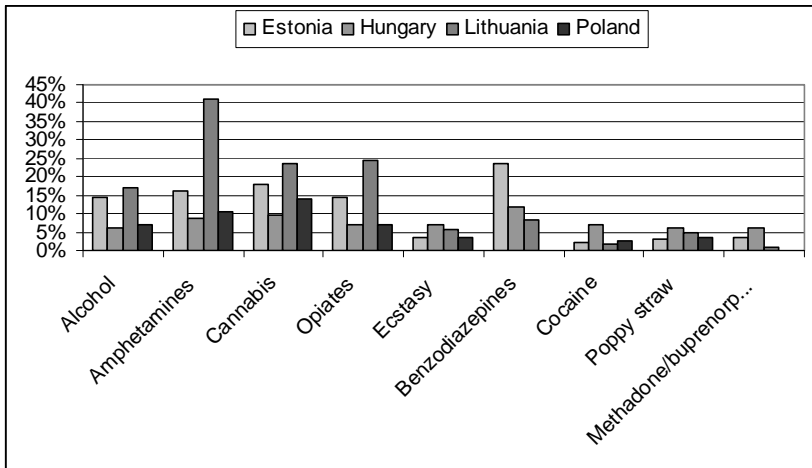


Fig. 51 Drug use inside prison, all four countries

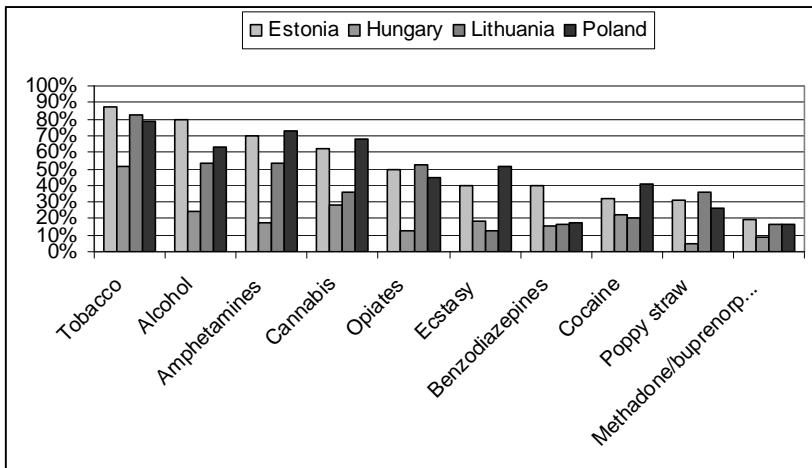


Fig. 52 Drug use outside prison, all four countries

The availability of illegal substances in prison according to the inmates' rating is with 36.7% rather or very easy and 63.3% rather or very difficult. Significant differences are found between men and women, the latter rating

the availability of illegal drugs in prison more difficult. This also corresponds with the lower drug use prevalence of the women inside prison compared to the men. The issue of availability also varies a lot between the four countries. In Estonia and Hungary the vast majority of inmates state it very difficult or rather difficult to acquire drugs in prison, while in Poland and Lithuania it's less than half the sample.

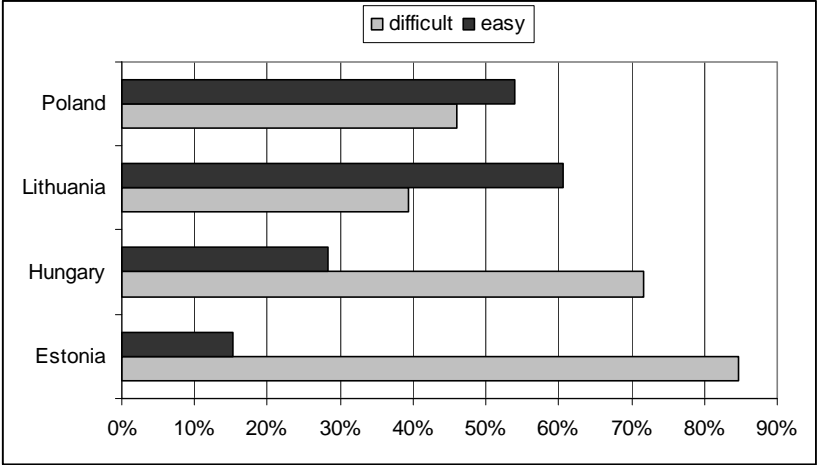


Fig. 53 Acquisition of drugs in prison

22.9% of the sample estimate sexual violence to happen in prison, 50% (other) physical violence and 66.7% psychological violence.

Risk behaviour takes place in the prisons to a rather large extent; tattooing is reported by almost half the sample (47.4%), other behaviour is reported less often: sharing a razor blade by 12.5%, and body piercing by 9.1%.

Health services most often desired by the inmates are health education training (44.8%), detoxification with medication (39.7%), individual counselling (38.4%), prison drug services (35.4%) and peer-support (33.9%).

The treatment quality stated by the inmates does not differ that much between countries. In Hungary almost one third of inmates stated the treatment quality to be very good or rather good, while in the other countries it is less than a quarter.

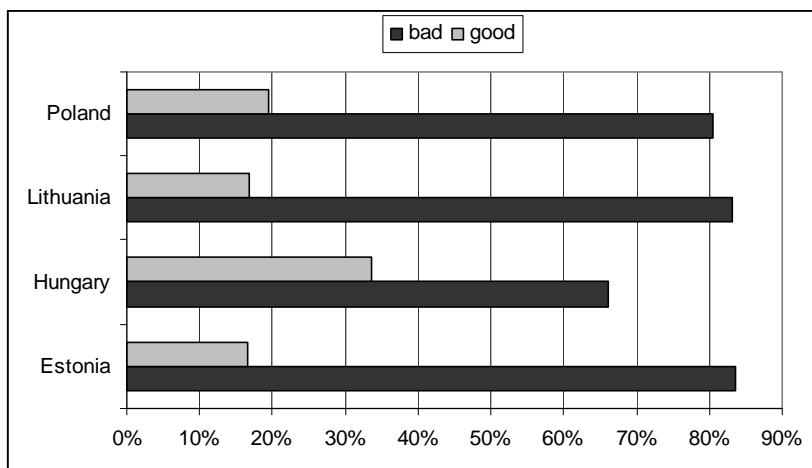


Fig. 54 Rating of treatment in prison, all four countries

4.6 Identifying common and structural problems

As can be seen in the presentation of the results in all four countries, although some issues seem similar among the four countries (e.g. long sentences), the country samples differ a lot regarding drug use, help services, infectious diseases. Therefore the focus in treatment might need differentiation regarding approaches and emphasis.

In the following the common and structural health care problems are being identified.

4.6.1 General resistance to harm reduction services for drug users

This study is seeking to better analyse obstacles and contradictions of prison health care and drug services in particular in greater depth, looking specifically at key prison harm reduction measures including condoms, sterile needles and syringes, opioid substitution therapy and bleach/disinfectant programmes. The study seeks to understand resistance to the introduction of these harm reduction measures and other health care matters.

In trying to understand staff resistances to harm reduction, it is necessary to go back and examine the underlying attitudes towards health care for prisoners generally – and drug use in prisons specifically – among both prison

workers as well as general society, as each plays a role in influencing the context in which decisions on prison health services are made. These attitudes can range from ingrained societal prejudices, such as the widespread perception of prisons as being ‘5 star hotels’ (Hassim, 2006) or that that ‘bread and water’ should be sufficient for people in prison, to ignorance of scientific evidence supporting harm reduction interventions or an attitude that poor health care is a legitimate aspect of legitimate punishment. Thus ignoring also the fact that the punishment lies in the deprivation of freedom, and not in the deprivation of adequate food and/or treatment.

Despite an extensive body of international human rights law and guidelines outlining adequate standards of health care in prisons (Lines, 2008), these attitudes and prejudices remain powerful factors in determining prison health policy. For example, in many countries visited for the project, both government officials and representatives of prison administration were aware of the above international guidelines, and in some cases were supportive of introducing health care measures to bring their national standards into line with international requirements. Yet despite these commitments, political obstacles and cultural resentments hindered or altogether blocked the implementation of health reforms, resulting in an overall prison health system that was very poor.

Health care in prisons is an ideal field for ‘symbolic policy’, where officials or the public can demonstrate ‘toughness’ and ‘law and order’ by approaching health services as an issue of crime and punishment rather than one of public health, let alone human rights. This often can make prison health programmes vulnerable to narrow political interests and political campaigns.

For example, between 2001–2004, well established and successful syringe exchange programmes operating in six German prisons were terminated following elections. It was clear that the termination of these programmes was politically and ideologically motivated, and the decisions ignored six years of evidence of the successful prison needle exchange implementation in Germany. The decisions were made without consulting prison staff (many of whom supported the programmes), but instead driven by political objective to abolish harm-reduction measures and establish drug-free prisons as the main policy objective (Lines et al., 2006; Stöver and Nelles, 2003).

More recently in 2006, a newly elected conservative government in Canada abruptly cancelled a ground-breaking and innovative safer tattooing pilot programme that had been set up the previous year in six prisons. The pilot

projects were initiated by the Correctional Service of Canada to reduce the risk of HIV and hepatitis C transmission via sharing and re-use of home-made tattooing equipment. They were a ready-made political target for a party running on a ‘law and order’ platform, which cancelled them shortly after assuming power, before the evaluations had even been done, in a decision described as ‘fiscally irresponsible and a threat to public health and human rights’ by HIV/AIDS advocates (Canadian HIV/AIDS Legal Network, 2006).

The interviews with prison staff and government officials identified a number of common arguments used against the introduction of evidence-based harm reduction measures (see below).

4.6.2 *“Prison health care is of better quality than public health care”*

In several countries, many of those with responsibility for prison health care who were interviewed were of the opinion that the prison health care is of a better quality than public health care in the community. This seems to be a widespread perception in many countries, with the related belief that prisoners were privileged to receive health care of a standard and promptness – and with free medications – that is not the case in the community. This then leads to certain attitudes which restrict additional and necessary efforts, such as the belief that ‘In prison their life is prolonged’.

The quality and availability of access to health care in prisons can only be understood in the general context of health care delivery in the community. In prisons, it is the prison service that has responsibility for health care. Therefore, prisoners are completely dependent on their health care professionals, and are not allowed to go out and choose the best treatment and the most reliable and confidential medical and health services. They are even not health insured while in prison and thus can neither afford medication nor treatment.

Quite apart from the assumptions reflected in the above statements, the study found structural conditions within prisons that undermined, rather than enhanced, access to health services. For example, there was a drastic decrease in availability of drug treatment and harm reduction services in prison (e.g. opioid substitution treatment, needle exchange programmes, psychosocial care). In many cases, there was a discontinuation of treatment started in the community. The researchers identified restricted access to medical services and medications, including special restricted lists of medications that doctors

and nurses were allowed to prescribe, consisting mainly of Aspirin[®] and Paracetamol[®]. Other structural problems included interruption of treatment (e.g. Antiretroviral Treatment (ARV) treatment) on release, which reveals a lack of cooperation and communication between prison and public health agencies, limiting the patient's ability to comply with treatment in his or her home community.

4.6.3 Denial of a drug problem, denial of an opiate-related problem

Similar to the developments in Western Europe 15–20 years ago (Stöver, 1994), where the drug problems in prisons appeared much earlier, a common reaction of prison officials interviewed was to deny the existence of a drug problem, an opioid problem and/or blood-borne virus-related health problems in prisons.

Admitting use of illicit drugs in prisons is often perceived, both inside prisons and among the wider public, as a failure of security. Therefore, pragmatic discussions of drug policy and harm reduction are always difficult in the prison context. This was also the case among those interviewed for the study. Furthermore, there was also a tendency to downplay the spread of blood-borne viruses as in many of the countries visited there was no prison-specific data and studies available. The debate on harm reduction was therefore characterised by the use of assumptions on both sides. Because of this lack of data, no specific targeted interventions for prisoners who inject drugs were being introduced. However, drug use does occur in prisons, although it is often less frequent than outside of prisons, and the use of drugs is often associated with a high risk of infections as hygienic precautions cannot be taken behind bars.

A common argument against the introduction of harm reduction measures in prisons was the assumption that amphetamines and/or benzodiazepines were the most widely used drugs, thus there was no need for opioid-centred harm reduction measures. Therefore, harm reduction interventions based on the needs of opiate users – especially opioid substitution therapy – were not seen as relevant or necessary. However, even where this assumption is true, this does not in fact undermine the need for harm reduction measures such as syringe exchange, as the same risks of transmitting HIV/HCV via syringe sharing exist, whether one is injecting amphetamines or opiates.

4.6.4 *Lack of understanding of the nature and dynamics of drug dependence*

Another factor increasing resistance to harm reduction was poor understanding among many officials interviewed of the nature and dynamics of drug use and dependence.

Opioid dependence in prisons is a widespread phenomenon, and estimations presented in a systematic review on intravenous drug use or dependence in prisons range from 10% to 48% in male prisoners (eight studies, n=4293), and in female prisoners (six studies, n=3270) from 30.3% to 60.4% (Fazel et al., 2006). Striking then was the fact that most of the interviewees had a limited understanding of the dynamics of opiate dependence, which is a chronically relapsing disease in which side consumption and ‘topping up’ with other drugs are quite common and part of the nature of dependence, especially in confined living conditions like detention.

This poor understanding contributed to widespread assumption that opioid dependence could be effectively interrupted for the time of imprisonment, which correlated with the assumption of prisons as drug-free zones. This misinformation was often entrenched as a result of anecdotal experience, as many prisoners appeared to improve their health and weight dramatically in a very short period of time after incarceration, and ‘look healthier than they arrived’. However, a structured day-night rhythm, as well as regular meals, are often more responsible for these physical changes than is overcoming drug dependence.

The problem in addressing this misinformation was exacerbated as prisoners who used drugs themselves often shared this superficial perception of opioid dependence, and did not reflect the dynamics of addiction, trigger situations or craving symptoms. Prisoners often wanted to reduce even their substitution doses quickly, and attempt to be drug free for their time of imprisonment.

Many officials interviewed thought of drug dependence as a phenomenon that flowed from hedonistic impulses, rather than as a disease or a behaviour that comes from the need to manage cravings or withdrawal, or to occasionally experience the familiarity of drug use. As a result of this thinking, the consequences of coercive abstinence in prison settings were not recognised by prison officials. The consequences include relapses immediately upon release, often resulting in overdose, drug emergency cases and death. Indeed, there is a twenty to fifty fold increase of drug related deaths in the first week

after release, this drops by 50% per week and plateaus at four weeks (Farrell 2005).

4.6.5 The myth of 'control' of the spread of infectious diseases

Another common perception among those interviewed was that knowing exactly who was HIV infected (in the cases of doctors and nurses) or knowing the number of HIV infected prisoners in absolute figures (in the cases of prison governors, Ministry of Justice) was central to HIV prevention efforts in prisons. The assumption was that if prisoners living with HIV are identified and effectively 'controlled', then transmission risks in prisons would be substantially reduced. The fact that some of the jurisdictions visited, such as Lithuania, used compulsory testing in prisons shows the policy effects of this approach, and the belief that if HIV-testing is done, the situation is under control.

These perceptions unfortunately illustrate a lack of understanding of the dynamics of blood-borne virus transmission in custodial settings, and the limitations of mandatory testing as a tool in HIV prevention (indeed the UN and WHO guidelines oppose mandatory HIV testing of prisoners: UNODC and WHO, 2006; WHO, 1993). Furthermore, as this approach is solely focused on HIV, it completely fails to address other blood-borne viruses, such as hepatitis B and C, as well as sexually transmitted infections.

4.6.6 Stigma

Another factor identified that hampers the implementation of harm reduction programmes in prisons is the general attitudes of prison staff and officials towards people who use drugs. In many countries in Eastern Europe the stigma of 'Narkoman' is common, the general association of which is being unreliable, unstable, non-compliant or untrustworthy. This stigma towards people who use drugs is also found in many Western European countries, for example 'Giftler' in Austria, and 'Btmer' in Germany or 'Junkie' in the United Kingdom. These negative attitudes towards prisoners who use drugs undermines efforts to expand health services, as they are perceived as being 'unworthy'.

In several of the interviews being led in the attitude of professionals and even active responses negative attitudes and prejudices against 'Narkoman' can be noticed. Prisoners often feel the stigma.

4.6.7 *“Harm reduction is not implemented in prisons in most European countries, so why should we do it here?”*

This attitude was a very common one expressed by the people interviewed. As noted earlier, most European countries have failed to implement comprehensive harm reduction services, or to scale up services to the degree necessary to make them accessible to all prisoners. This generalised failure among European prison systems became in itself an argument used by prison and government officials against the implementation of harm reduction measures in their own country.

However, this overall failure of European prison systems to implement comprehensive harm reduction services is more a measure of the common barriers in their scale up (some of which are identified in this study), rather than on the need for, or effectiveness of, these interventions. Indeed, the failure of other governments to implement harm reduction should not prevent other countries from taking action to prevent the spread of blood-borne viruses in prisons (Juodkaitė et al., 2008).

Taken together, the interviews clearly illustrate the dissonance between what is being done to address blood-borne viruses in prisons, and what should be done. Despite the body of scientific evidence showing the effectiveness of harm reduction measures, and their successful implementation in many prisons around the world, significant barriers remain to convince prison workers and policy makers of the need to implement these programmes.

The outcome of the interviews shows that, in general, the prison workers and officials:

- Are not convinced of the effectiveness of harm reduction programmes and mistrust the reported results. Therefore a theory-practice-transfer has not yet been realised.
- Consider that certain harm reduction measures are not applicable to their circumstances generally, or to prison settings specifically (e.g. opioid substitution treatment, syringe exchange).
- Believe that they lack the legal/policy framework, the human or financial resources and/or the knowledge to implement harm reduction programmes.

In Estonia for instance there were 670 HIV-positive prisoners at the time of the field visits; 100 of them received ART (half of the female prisoners were

HIV-positive), but there were no harm reduction measures applied, just information and social life skills groups.

Not only OST and needles and syringes were lacking but **condoms** (and lubricants) as well. It is a matter of condom availability and accessibility. In Estonia officially condoms are made available in shops, conjugal visit rooms and medical departments, but in practice this was not the case according to nurses and prisoners (exception: condoms only in conjugal visit rooms). Condoms are seen as provoking sexual abuse, as the assumption is that sex is happening only in form of rape. Obvious contradicting answers to the availability of condoms express the controversy about this issue. Lubricants and (extra strong) condoms were not provided in several prisons visited although this has been claimed by officials. The question is whether it is enough to make condoms only available in conjugal visit rooms and at the doctors practice room?

In Poland there was even no debate about condoms. Religious beliefs are weighted stronger than evidence from scientific studies.

Another topic for harm reduction measures is **tattooing**. For younger prisoners tattooing seems to be made of other motivation (body fashion) than in former times, where it indicated sub-cultural belonging and symbols. Also for this risk behaviour no preventive measure has been introduced in either of the prisons visited.

Disinfectants are provided in Lithuanian prisons, stored in the 'living/leisure space' but as usage might be supervised by guards nobody would make use of that according to prisoners. Prisoners fear to wash syringes because they fear being seen, caught and punished. The consequence is that they are using syringes several times and share the devices.

Prisoners have access to Chloramin, but it is supposed to be not strong enough, so nobody would clean the syringe in the bucket.

4.6.8 *Overcrowding and lack of resources*

Overcrowding is an important issue in delivering health care and maintaining health of prisoners and staff. Table 43 indicates that overcrowding is only an issue in Hungary (especially in the women's prison), although in some of the other sample countries this was partly perceived as well.

Table 43 Occupancy level and prison population rate

Country	Occupancy level (prisoners per 100 places)	Prisoners per 100,000 population
Estonia	97.2% (1.1.2010)	265
Hungary	127.7% (31.12.2009)	153
Lithuania	85.5% (1.7.2008)	260
Poland	95.9% (31.8.2010)	212

Also massive budget cuts during the last economic crisis were influencing the availability and quality of health care services (prevention, test kits etc.). Furthermore prison health care seems to be not attractive to doctors, thus it is hard to find doctors for vacant jobs (e.g. Poland). These have to provide health care for a difficult clientele in difficult circumstances. The same applies to nurses in some countries.

The number of personnel is not being adjusted to the number of prisoners: In Hungary for instance there were 5 prison doctors for 1,200 prisoners, but this remained the same in times, when there were 2,000–2,600 prisoners. In Estonia and Poland also more doctors and nurses are needed.

4.6.9 *Involvement of NGOs*

The pivotal and trust building role of NGOs especially in dealing with topics like drug use and infectious diseases has been described by many authors. However, in the prisons visited not many NGOs in the field of illegal drugs have been employed. This is different for alcoholics, where several church-near institutions are involved.

4.6.10 *Problems of health care in detail*

During the field visits in the sample countries a lot of common problems in everyday health care provision have been identified. In the following the most important areas are listed. Sometimes there were big difference between official views and those of prisoners.

a.) Major health problems perceived by doctors and nurses

Asking doctors and nurses in the prisons visited about the major health problems of prisoners the following areas have been identified in the sample countries:

Estonia

- HIV/AIDS,
- Drug consumption
- dental problems (Estonia, Tallinn male institution)

Hungary

- Personality disorders/problems after spending many times in prisons
- Heart diseases, vein problems
- Skeleton problems
- Digestion problems (Hungary, Budapest male institution)
- head aches
- stomach aches
- sleeping disturbances (Hungary, Budapest female institution)

Lithuania

- compliance and adherence of therapies
- dental problems
- withdrawal symptoms from drug addiction (Lithuania, male prison)
psychological health
- digestion problems
- gynaecological problems, (Lithuania, female prison)

Poland

- Hepatitis
- (probably) TB, which is rising in the community
- Resistance of prisoners (compliance and adherence)
- Drug use
- Skin diseases
- HIV
- TB- supervision (female prison)

b.) Underestimation of the spread and infection risks of hepatitis

Although there are some data about the prevalence of HCV the health discussion in the sample countries is merely or solely focusing on the prevention, testing and therapy of HIV and AIDS. There seems to be an underestimation of the spread of other BBV infections, especially hepatitis B and C. In several countries there are no HCV treatment options. In prisons with a high percentage of estimated drug users, but also in Hungarian prisons, HCV is spread as well (in one study 15% of prisoners were HCV positive). Subsequently to the

lack of HCV – treatment, HBV-vaccination is either not done or only for risks groups and then of prisoners with a sentence more than seven months. Like in the general society for the spread of HCV there is a huge dark number in prisons as well.

c.) Drug consumption and related risk behaviour: sharing of injection equipment

One of the problems encountered during the field visits is the widespread use of illegal drugs (e.g. Lithuania). In some institutions visited approx. 50% of the prisoners are using illegal drugs. Some of the prisoners reported that “it is quite uncommon if somebody doesn’t use drugs”. This is quite likely in institutions where a huge proportion of prisoners is known as drug users (e.g. Lithuania, where out of 250 female prisoners, 100 are known to be users of opioid and/or other illegal drug (25 of these are thought to be dependent and are actively using in prison). Furthermore alcohol is a vast problem as well. In the female institution mentioned above there were 72 alcoholics.

Another example comes from focus groups in Estonia, where drug use is taking place in prisons as well and if taken intravenously, according to the prisoners interviewed some 15 prisoners are sharing the needle, for more than two months, sharpening the needle by the window glass, some are boiling, the rest is sharing, nobody cares for infections, those who are negative boil for some minutes. From Lithuania it was noted that even 30 prisoners are sharing one syringe.

Appropriate therapeutic and counselling answers with target-group specific messages and offers have to be created here.

d.) Few patients in Opioid Substitution Treatment (OST)

Although there are many (former) opioid users incarcerated, only Poland has introduced OST yet (in three prisons). Methadone treatment is being introduced in

- Montelupich (Krakow)
- Mokota
- Sluscjewiecz
- (one more in preparation at Rzeszow).

The basic problem in introducing OST seems to be on the one hand the lack of possibilities to continue the treatment after release. On the other hand the fact that opioid dependent prisoners often get into the prison institution after

they spent already days, weeks or even months in police detention where they already run through a withdrawal process.

OST is required from prisoners in the focus groups at least for detoxification purposes in several prisons visited.

Police custody and withdrawal is a big issue among respondents. No medication is given usually, 'cold turkey' is normal. Drug users are not given any medicine, because they are drug users, and people fear unpredictable interactions because they are drug users. Therefore OST should be given in police detention units or for detoxification purposes. Methadone should be used for withdrawal, already in police custody or in the arrest/pre-trial house.

e.) Focusing predominantly on organisational offers

Focusing on one approach only, like DFU or other abstinence-based counseling and treatment and support by contingency management (better housing, parcels, visits, equipment, less prisoners on the cell), might not be the solution, although stepping into the right direction.

f.) Communication and cooperation between different doctors

In some prisons visited the communication and cooperation between medical doctors was perceived as problematic. In some countries only psychiatrists are allowed to prescribe certain medications (e.g. benzodiazepine). This is even being done on a permanent basis (Rivotril® in Hungary). GP prison doctors obviously have to tolerate this policy. Thus communication and cooperation between these two specialist groups is lacking.

g.) Women's health

A central problem of women's health is that incarcerated women do not adjust to the female role model, especially for prisoners who are mothers. This is influencing not only relative's, family's, but also professional's attitude to this group, this may be one of the reasons why women's needs are not being addressed properly in many ways (e.g. different shopping list – "shopping list is male oriented"). Another problem is that due to the small number of female prisoners they are incarcerated centrally. Subsequently this means for female prisoners that their partner children, relatives have to come long distances for visits and support. In some female prisons visited self harm is an issue during the whole sentence and not only in the first weeks as reported in several scientific papers.

h.) Complaints of prisoners

Availability and suitability of medication

Some of the complaints heard from the prisoners were focussing on the availability of the right medication. Often prisoners complained about the fact that either the right or prescribed drug in the community was not available in the prison pharmacy or was not given by the nurse or doctor. This accounts for instance for the transfer from prison hospital to the prison where the medication often was not available. Also the medication known from outside sometimes was not available inside e.g. diet. Sometimes the mode of consumption of medication could not be kept.

Other complaints of prisoners were focussing around the need for more vitamins. In some prisons due to financial reasons vitamins provision was cut. Also fruits were not purchasable, only garlic and onions.

Some of the discussions around the right and suitable medication obviously were lacking communication between doctor/nurse and patient. Patients need information about the medication they are given – even more in prison, because mistrust often is widespread. This is then a breeding ground for rumours of all sorts. A lack of information has been expressed by prisoners in Hungary when they are given even strong drugs like barbiturates without proper information. This accounts also for the sufficient discussion of and information about side effects (e.g. ARV treatment). In Lithuania interviewees said that they perceived the HIV-test as obligatory. Those who refuse the test are sent to Alytus prison (where the HIV outbreak happened in 2002). If Alytus prison is specialising on HIV/AIDS treatment and prisoners who refuse the test are being sent to Alytus they perceive this as a stigmatising measure.

In countries with a high HIV-prevalence (e.g. Estonia) more understandable information about effects and side effects of ARV-treatment is demanded, which is the basis for more involvement in decision making about the start of treatment.

In prisons where there was a high spread of HIV, consultation and support has been expressed to be needed regarding the decision to start ARV treatment etc. Medical personnel doesn't think this is needed, because they think it can be covered by their own services. However, HIV-positive prisoners feel being left alone with their fears. According to some professionals HIV and ARV-treatment are difficult subjects, which need to be translated properly.

Some prisoners feel being pushed to treatment, which is not a suitable basis for confidentiality and adherence to treatment. Although prisoners are informed by the doctors about ARV-treatment, according to prisoners it is not understood. Adherence to treatment might be higher if patients understand the procedure and cooperate actively.

Furthermore prisoners often were not satisfied with the treatment given to them. In some interviews prisoners (all HIV positive) expressed their wish to see an infectiologist, but this was not possible for quite a while. Due to organisational reasons it was sometimes impossible for them to take the ARV-medicine at the same time of the day. One prisoner reported that he has been sent to the isolation cell (carcer), and hasn't got his ARV-treatment for 4 days.

In some countries dissatisfaction with medications has been expressed (“tablets are all given out of one jar, several prisoners with different symptoms get the same medication ...”; “most often prescribed medications are: paracetamol and aspirin”).

Long waiting lists to health care and drug treatment

Long waiting list have been identified (e.g. for dentist) by prisoners. Dental health of prisoners is often unsatisfying and services like in Estonia have been perceived as insufficient (dentist 1 x per week for 2.5 h; if 80% of teeth are missing then payment and therapy was possible. Prisoners were ready to pay for it, but this was told to be impossible).

Long waiting lists do also exist with regard to access to drug treatment. It is an indicator for an unbalanced demand – supply relation: In Poland for instance there are 15 drug therapy units, although these services increased over the last years there are still long waiting lists, partly even longer than before. In Warsaw prisoners have to wait for even 18 months for treatment.

Lack of continuity of treatment, sustainability of efforts

In Poland prisoners first go back to the prisons where they come from, without any additional programme there. According to the prisoners abstinence is a fiction because they are put in the same (drug using) environment. Prisoners interviewed expected to go on conditional release; in their prisons, but instead they are considered as IDUs in their origin prisons. So there is the risk that the positive achievements are run down again in that time in prison.

Lack of Confidentiality in drug treatment units

It is very important in terms of confidentiality who is providing the health, social and/or psychological service and how this services are organised in prisons. Problems of confidentiality have been identified in Poland where psychologists were working in therapy units, prisoners participating in these units express their fear that contents is being told to other persons in the prisons.

Sanitary conditions

Prisoners complain about hygienic conditions, as they say that doctors don't respect the hygienic needs of prisoners, e.g. dentist doesn't change the gloves and the tools they use. They fear getting infected by the dentist.

5 Barriers to improvement of health care in prisons and requirements to ensure sustainability

The following chapter outlines the key requirements needed in order to successfully implement sustainable health care services in prisons. Looking at good practice examples in the prisons the countries visited demonstrate, it is possible to overcome barriers to implementing effective and efficient health care services especially for incarcerated drug users, it is important to acknowledge the requirements that need to be in place to overcome the various problems that occur. There are certain requirements that need to be formulated at all relevant levels: attitude towards and knowledge about drug addiction and health risks for all key actors, necessary changes both at the policy and practice level. Guidelines, protocols, advices need to be formulated from evidence-based practice, as opposed to moral and value judgements. Previous research highlighted in chapter 3 has demonstrated that crucial elements of health care services are already well established and well evaluated in prisons and the wider community, providing a firm foundation for other countries and prison administrations to further develop their own services.

5.1 Overcoming institutional challenges

Despite obvious damaging health risks for prisoners and prison staff (Bögemann, 2007; Stöver & Michels 2010) the obstacles to and arguments against target group specific and evidence-based services for drug users within prisons have remained disturbingly constant through the years (Stöver/Lines, 2006). Prisons are by definition places of secure custody and this security-based ethos infuses policy in all areas of prison life, including the provision of health care. Therefore experts stress the necessity to regard prisoners also as patients (Coyle, 2007) with specific and defined ethical basis (Hayton, 2007; Restellini, 2007). Prisons are also rooted in a culture of surveillance, in which prohibitionist approaches towards drug use are even more firmly entrenched than in the outside community. Both of these characteristics are sources of resistance to the implementation of adequate health care services, effects prevention, treatment, care and support. The security-based ethos has meant that prison systems have traditionally viewed health threats from a perspective of institutional security, rather than from one rooted in health care or human rights. As a result, prisoners living with HBV/HCV, TB or HIV/AIDS, drug users have often been dealt with as security risks to be con-

tained and controlled, rather than individuals in need of compassionate and specialized health services. The most blatant manifestations of this coercive approach have been policies of mandatory HIV testing and of isolating HIV-positive prisoners.

While such policies have been largely – but by no means totally – eliminated in European prisons in favour of voluntary testing and integration, the attitudes underlying them remain in force. According to this coercive security-based ethos, OST, syringes, condoms¹⁰ and bleach are seen only as potential weapons and/or instruments for criminal behaviour (e.g. trafficking methadone). Requests by prisoners living with HIV/AIDS for pain medication to relieve what is often severe HIV-related chronic pain are regarded as ‘drug-seeking behaviour’. The provision of substitution treatment is seen as undermining abstinence-based approaches to drug use. And the compassionate release of terminally ill prisoners living with HIV/AIDS is considered a security risk to the community outside.

A recent study found that security constraints common to most prisons may lead health care workers to engage in risky behaviours that increased their risk of blood-borne infections. The study found that nearly 29 percent of correctional health care workers “frequently or always” recapped used needles – that is, replaced the needles’ protective plastic cap – a behaviour that greatly increased their chances of getting pricked by a contaminated needle. The report suggested that the high rate of needle recapping among correctional health care workers was due in part to having to keep used-needle containers locked away in secure rooms. Similarly, the researchers found that hand washing rates were below average among correctional health care workers, and laid some of the blame on prison employees’ diminished access to sinks and soap in the prisons (Stöver/Lines, 2006).

5.2 Overcoming abstinence orientation as pre-dominant response

One important obstacle for not introducing harm reduction measures in prisons is the basic *abstinence-orientation* to be found in many prison visits throughout the research. This accounts not only for doctors, nurses and other responsible persons in the prison service but for prisoners themselves. This goal is identical with the goal of the sentence itself (to enable prisoners to live a life without committing criminal offences, i.e. drug consumption, deal-

¹⁰ To hide drugs in the body.

ing). Despite the fact that drug use occurs in prisons and where the consequences to health are clearly visible, the goal of abstinence remains, and it encourages at the expense of considering other goals, such as methadone maintenance for those who do not wish to cease using drugs during imprisonment, and syringe exchange programmes to prevent the spread of communicable diseases. Harm reduction measures for instance are seen in the model of prison as a time of abstinence as conflicting with the needs of prisoners and staff, and also as condoning criminal activity within a criminal justice setting. Several interviewees feared that dealing with the reality of drug use in prisons and designing harm reduction measures would be the wrong signal leading to an affirmation of drug use.

The reasons for resistance against the introduction of harm reduction measures and other target-oriented health care services for prisoners are manifold, but basically to be found in the very structure of closed settings like prisons:

- fear of being known as a drug user/addict,
- fear of losing privileges,
- fear of not getting onto work or qualification programmes,
- fear of partners, family and relatives knowing they are using drugs in prisons.

Abstinence orientation requires systematic approaches to achieve and/or maintain abstinence from drug use in prison or reduce harmful drug using patterns:

- Providing standards and diversity of drug services in prisons to match those available outside of prisons.
- Counselling on drug and HIV/AIDS-related issues (provided by prison staff or specialised personnel, integration of external drug services).
- Housing of drug using prisoners in specialised units with a treatment approach and multidisciplinary staff.
- Provision of voluntary drug-free living units.
- Provision of print media and audio-visual material (in different languages, and including the involvement of counselling agencies from outside the prison in the production of this material).

However, it should be accepted that it is often unrealistic to expect drug-using prisoners to change their behaviour drastically and sustain that change while in detention (i.e., to live drug free). Providing services to drug-users in detention is designed to give them an idea of a realistic and alternative life-

style, and assist them to raise and strengthen self-motivation and feelings of responsibility and to accept changes only occur gradually. Providing a variety of aids that help drug-users to become aware of alternatives must support these attempts.

5.3 Information, education and communication

Changes in the attitude regarding drug addiction, HCV/HIV-positive prisoners and people living with HIV/AIDS can first be initiated by extensive programmes of information, education and improvements in communication. Transparency is the key word to be communicated for all relevant status groups.

Prisons are institutions characterized by a coercive and punitive ethos which is reinforced both by the institution and also by the prison subcultures. Prisons are also environments in which new and probably unexpected risks are presented for prisoners that they may not have faced when living in the community (i.e. clandestine and quick drug use with shared needles, sexual contacts with the risks of being discovered either by other prisoners or staff, rape or other non-consensual sex, tattooing with contaminated needles). For some, prison is the place where they first begin injecting drugs, take new and probably risky mixtures of drugs, while for others it is used as an opportunity to reduce or even stop their drug use.

Prevention programmes with a harm reduction orientation must therefore reflect these particular conditions and individual responses and behaviour in order to be effective. Community-based strategies cannot simply be transferred into the prison setting without responding to the particularities of the risk environments and the limitations available for behaviour change (e.g. lack of access to sterile syringes). If prevention messages are to be accessible and relevant to the target group, specific living and risk conditions must be identified and prevention strategies tailored to these circumstances and different target groups (Stöver/Lines, 2006).

The use of modern educational methods (e.g. interactive methods) and of visual aids is now well established. Seminars directed to a better understanding of problematic or risk behaviour will produce more effective collaboration between prisoners and staffs in reducing the spread of HCV/HIV. Involving drug users in developing, designing and delivering information materials is critical to increase their appropriateness and effectiveness. The content should cover both the risks of injection and sharing practices and

advice on how to reduce these risks and avoid sharing. But harm reduction measures should also be designed towards risk behaviour which is merely a taboo (like unprotected sex). The WHO recommends:

“To deliver information through a variety of channels, including general awareness campaigns, providing targeted information through health and social services frequented by problematic drug users and delivering information through peer and drug user networks and outreach workers. Harm reduction counselling is based on face-to-face communication and provides an opportunity for drug users to turn information into actual behaviour change through a process of clarification and reinforcement” (WHO, 2005: 8).

The WHO/Europe (2005) also stresses the importance of considering the particular needs of imprisoned ethnic minorities. Western European countries are facing a high percentage of foreign prisoners in their prison systems, therefore it is necessary to first look at the language which is the most obvious barrier. Many ethnic minority prisoners would have experienced difficulties in accessing health and social care before admission and this could affect their health and addiction problems. Other models are the integration of foreign language speaking mediators and interpreters. As Europe already has a high proportion of foreign nationals in prisons, a range of measures may be necessary to facilitate information, education and communication among them.

Target group specific education is needed which is directed to the various and heterogeneous needs and resources of different prisoner groups and staff groups. This would include new strategies of transporting prevention messages (e.g. interactive ways, role plays of safer use and safer sex¹¹, as well as peer education initiatives for both prisoners and prison staff) (Stöver/Lines, 2006). But within the prison environment it is not only the prisoners who need HCV/HBV/HIV/AIDS services, as prison staff may be placed at increased vulnerability to HCV/HIV infection because of unsafe working environments. In many cases, misinformation about routes of transmission of infectious diseases – in particular the false belief that prison staff are placed at risk of HCV/HIV infection via casual contact with HCV/HIV-positive prisoners – leads to both anxiety among prison workers and to human rights

11 See with many practical examples: Stöver, H.; Trautmann, F. (ed., 2001): Risk Reduction For Drug Users In Prisons. Utrecht/The Netherlands (available in English, German, Russian, Estonian, Latvian, Lithuanian, Slovenian).

abuses of prisoners living with HIV/ AIDS. Therefore educational and training programmes for staff are essential.

5.4 Adjustments in regulations and legislation

Frameworks of legislation, prison policy, and prison rules are necessary to promote effective and sustainable health care responses to drug addiction, infectious diseases and other damaging health challenges in prisons. Under international human rights law, states have the primary responsibility for respecting, protecting and fulfilling human rights obligations, including the right of all persons to enjoy the highest attainable standard of health. These are rights enjoyed by all persons, including persons confined in penal institutions. Therefore national governments and international assemblies have an obligation to ensure that rights to health care are not denied to prisoners.

International and national legislative and policy frameworks, and national and local prison policies and rules, directly affect prison management and prison regimes, and have the potential to promote or impede progress in reducing HCV/HIV transmission in prisons and caring for those living with HCV/HIV/ AIDS in penal institutions. Therefore, national and international legislative and policy reform – as well as reform of prison policy and rules – should accompany the development and implementation of an effective and ethical response to health challenges in prisons, and to health care in prisons in general.

Often a reform of regional regulation, national and international legislation is necessary in order to influence the development and implementation of prison policies, prison rules, and prison programmes. Therefore the actions taken at the national level can make an important contribution to creating an environment that promotes and encourages the development of effective prison management, prison health programmes, and the ethical treatment of prisoners.

This is especially true for the continuation of treatments. The example of the introduction of substitution treatment in Polish prisons demonstrates, that the level and speed of expansion of this therapy form depends completely on the number of places available and the coverage of substitution programmes in the communities throughout the country. If places in such programmes are generally scarce and limited, it seems problematic if not unethical to provide these treatments in prisons if no continuation is foreseen after release.

5.5 Reduction of prison populations and prison reform

Overcrowded prison conditions are detrimental to efforts to improve prison living standards and prison health care services, and to prevent the spread of HCV/HIV infection among prisoners. Overcrowding presents barriers to implementing HBV/HCV/HIV/AIDS prevention and education efforts and creates conditions for increased prison violence (including sexual coercion and rape). Overcrowded living conditions also increase the likelihood that the health of prisoners living with HCV/HIV/AIDS and other health damages will suffer through exposure to other infectious diseases and to unhygienic conditions, and create additional impediments to the ability of prison medical staff to provide adequate health services.

The overuse of incarceration of drug users is of particular concern. In many countries, a significant percentage of the prison population is comprised of individuals who are convicted of offences directly related to their own drug use (i.e. those incarcerated for the possession of small amounts of drugs for personal use, those convicted of petty crimes specifically to support drug habits). The incarceration of significant numbers of drug users increases the likelihood of drug use inside prisons, and therefore an increase in unsafe injecting practices and the risk of transmission of infectious diseases. Overcrowding is likely to reduce chances for individual responses and is likely to breach confidentiality simply because an ordered approach is less possible.

Action to reduce prison populations and prison overcrowding should accompany – and be seen as an integral component of – a comprehensive strategy to prevent the transmission of infectious diseases in prisons, to improve prison health care generally, and to improve prison conditions. This should include the development of non-custodial strategies to reduce the over-incarceration of drug users, and to establish government targets for reducing prison overcrowding generally. Finally measures to reduce the size of the prison population would have great benefit and achieve considerable savings (Black et al., 2004).

5.6 Commitment and political and management leadership

Political and management leadership already in the process of finding a consensus in implementing or expanding target group specific health care is necessary. Government officials, policy makers, and other relevant national and international stakeholders should take over responsibility and develop leader-

ship, which in a hierarchically structured and organised setting like prisons is of crucial importance.

The importance of political commitment and leadership has already been pointed out on international level. According to the Declaration of Commitment – United Nations General Assembly Special Session on HIV/AIDS (UNGASS Declaration) ‘strong leadership at all levels of society is essential for an effective response to the [HIV/AIDS] epidemic’¹². This is particularly important among prisoners who face higher risks and lack the necessary services and support to deal with health problems.

In many countries, prison health standards and prison conditions suffer because of a lack of political and public interest in the well being of prisoners. Taking action to address the broad concerns especially raised by HBV/HCV, TB and HIV/AIDS in prisons, and enabling prison authorities to implement effective policies and strategies like harm reduction, requires the political commitment to publicly identify prison health, improved prison conditions, and HCV, TB and HIV/AIDS as issues demanding government action.

Government officials, senior prison authorities, the judiciary, senior health officials, and other informed individuals and groups, including health professional associations, civil society organisations, people living with HIV/AIDS, prisoners/former prisoners, and prison managers and prison staff, have a crucial role to play in mobilising political support for prison-based harm reduction interventions, and in supporting government actions necessary to effectively combat health damages in prisons.

5.7 Overcoming resistance from prisoners and prison staff

Resistance of staff and prisoners themselves against harm reduction and specific health care measures has been clear from the research findings, although the reasons given for both groups are quite different.

Resistance of staff against harm reduction measures is based on:

- misunderstanding about the concept and basic idea of harm reduction,
- misleading information regarding the value and impact of such measures in the context of a basic drug free orientation,

12 *Declaration of Commitment – United Nations General Assembly Special Session on HIV/AIDS* [aka UNGASS Declaration], June 2001.

- fears of getting health injuries (e.g. needle stick injuries) and increased risks of the working place safety for prison staff.

Prisoners' resistance comes from:

- fears of getting known as an 'addict' or drug user to the prison staff and authorities (with all negative consequences such as being prevented from accessing work opportunities, frequent cell searches and of visits and home leave),
- fears of getting known as an 'addict' or drug user to other prisoners (with all negative consequences e.g. bullying, being put under pressure to share the medication),
- fears of getting known as an 'addict' or drug user to partners and family,
- admitting to the others having sexual problems when participating in courses for 'safer sex'.

However, prisoners tended to be more familiar with a wide range of harm reduction measures in the community, and although prisoners they do not object harm reduction measures as such, they are concerned about the negative connotations of these measures within the prison setting.

If harm reduction measures are to be introduced successfully and in a sustainable manner this resistance has to be overcome. Several strategies have been developed to address the needs of prison staff involved in the introduction of harm reduction measures. One key element of these strategies is to start from the health risks of staff to build a bridge to individual health risks for prisoners (Bögemann, 2007). The complex psychosocial problems (post-traumatic stress disorder, alcohol use, burn-out syndrome) of prison staff have to be reflected within a health promoting strategy in prisons as well.

Resistance against substitution programmes

Various factors have been identified which demonstrate the difficulties in implementing substitution programmes in prisons:

Basic drug free orientation – Substitution drugs are seen in this context also as hedonistic, psychoactive drugs (because it is also purchased on the black market from dealers who sell other illegal drugs) and not as therapeutic drugs as part of a medical treatment for drug addiction.

Lack of understanding of the nature of substitution treatment – Although many prisoners interviewed admitted relapses immediately after release, resistance against a continuity of prescription was expressed by several pris-

oners, who regarded their prison sentence as their only drug free time. These yo-yo effects were perceived as normal and not as explicitly health damaging.

Lack of understanding of the nature of drug use and drug dependence – Although in substitution treatment several prisoners wanted to reduce their dosage to zero shortly before release because they wanted to leave the prison ‘drug free’ either to avoid getting into the dependency of the methadone prescribing clinics outside again or wanting to avoid the drug scene around dispensing clinics. Unknowingly, this practice exposed them to enormous risks when relapsing. Prisoners want to hide their drug use for several reasons (one is that they fear prejudices and disadvantages for their current sentences as being viewed and treated as a ‘drug user’ when being in a substitution programme), which would become apparent immediately to other prisoners and staff when entering the medical units on a daily basis.

Engaging prison staff with harm reduction services – Several examples can be shown that prison staff can successfully and within a short period of time support harm reduction measures. The analysis of the introduction of harm reduction measures like needle exchange programmes in prisons (see chapter 4.4, also Meyenberg et al., 1999) convincingly shows that staff once educated and informed about the targets of specific programmes can be engaged in harm reduction measures.

5.8 Human rights legislation and international guidelines

As well as the structural and political barriers discussed above, the stigmatisation of prisoners has often meant that their right to health care has been ignored (Stöver/Lines, 2006). As a result, improvements in prison harm reduction services have often come about through advocacy. Prisoners are entitled, without discrimination, to the same standard of health care that is found in the community, including preventive measures. This principle of equivalence is fundamental to the promotion of human rights and best health practice within prisons, and is supported by international guidelines on prison health and prisoners rights. While HCV/HIV/AIDS prevention, harm reduction and treatment programmes in prisons have indeed improved – in some cases dramatically – over the past 20 years, the vast majority of prison systems are still failing to meet this equivalency standard, which predates the HCV/HIV/AIDS epidemic by several decades. It was articulated as early as 1955 in the United Nations Standard Minimum Rules for the Treatment of

Prisoners, Principle 9, which states, ‘Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation’. It has subsequently been reflected in numerous other international instruments¹³, as well as in national prison policy and legislation in many countries.

With HBV/HCV and HIV/AIDS, the principle of equivalence has taken on new and additional urgency, and a growing number of important international health and human rights documents have specifically applied it to hepatitis HIV/AIDS (Lines/ Stöver, 2006). WHO has shown important leadership in this regard. In 1993, WHO published guidelines on HIV infection and AIDS in prisons (1993), specifically applying the principle of equivalence to HIV/AIDS. *Principle 1* of the guidelines emphasizes, ‘All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination ... with respect to their legal status’. *Principle 2* further states that ‘general principles adopted by national AIDS programmes should apply equally to prisons and to the general community’. The guidelines go on to detail the key elements of a comprehensive and ethical response to HIV/AIDS in prisons. Although well over 10 years old, the documents’ continuing relevance is perhaps the starkest illustration of the failure of prison systems across Europe to meet their international obligations regarding health. Since 1993, WHO has published a series of important documents on the issue of HIV/AIDS in prisons. They include Prison, drugs and society (2001); the Moscow Declaration (2003); a policy brief on reducing HIV transmission in prisons (2004); Status Paper on prisons and Tuberculosis (2007), Trencin statement on prisons and mental health (2007), Women’s health in prison (2009), The Madrid Recommendation: Health protection in prisons as an essential part of public health (2010), and a status paper on prisons, drugs and harm reduction (2005) and finally

13 In addition to the other United Nations instruments mentioned, see also the Basic Principles for the Treatment of Prisoners (1990), as well as the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1982), which states: ‘Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.’ Additionally, in a 1996 statement before the Commission on Human Rights (1996), UNAIDS declared, “With regard to effective HIV/AIDS prevention and care programmes, prisoners have a right to be provided the basic standard of medical care available in the community”.

the Health in Prison Guide (2007)¹⁴. All have been important, both in highlighting the necessity of health care in prisons equivalent to that in the community and in providing advocates and NGOs with tools to fight for national policy change.

Another development since the mid-1990s that has helped drive health policy change and respect for human rights is the establishment of networks of NGOs and/or prison officials to share and promote models of best practice, and in some cases to engage in advocacy initiatives. Perhaps the most well known and influential of these has been the WHO Health in Prisons Project (HIPP¹⁵), established in 1995. Annual HIPP conferences and networking meetings have highlighted numerous prison health issues, including TB, HBV/HCV, HIV/AIDS. Similar networks created during this time but with a specific focus on HCV, HIV/AIDS and harm reduction include the European Network on Drugs and Infections Prevention in Prison (ENDIPP¹⁶) and the Central and Eastern European Harm Reduction Network (CEEHRN¹⁷). While the latter does not focus exclusively on prisons, it does provide an important forum for NGOs working on health in prisons.

The efforts of NGOs, medical experts and people living with HBV/HCV, HIV/AIDS (PLWHA) in many countries have been critical in advancing national prison health policy. Their work includes not only lobbying governments, but also providing hepatitis, and HIV/AIDS services directly to prisoners. Increasingly, hepatitis, HIV/AIDS has also been taken up as an issue by prisoners rights NGOs, who have added their voices to calls for improved hepatitis and HIV/AIDS programmes. International groups such as Penal Reform International and the International Centre for Prison Studies, as well as national NGOs such as the Irish Penal Reform Trust, have played important roles in promoting prisoners right to HIV/AIDS services. Perhaps the most significant example of civil-sector cooperation in recent years was the 2004 Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia (Lines et al., 2004), whose call for international action on HIV/AIDS in prisons was endorsed by over 100 NGOs and experts from 25 countries.

14 http://www.euro.who.int/InformationSources/Publications/Catalogue/20070521_1 (accessed 11th July 2007)

15 www.hipp-europe.org

16 www.endipp.net (accessed 5 May 2007)

17 <http://www.ceehrn.org/> (accessed 5 May 2007)

5.9 The need for protocols, standards of care and guidelines

In many ways clear protocols and guidelines are the result of professionals dealing with health challenges as they guide successful practice and deliver a systematic response towards health threats. Examples of good practice in the development of guidelines are to be found all over the world, including the EU, as are standards of care and protocols for dealing with issues that arise.

For example, in the UK the British Medical Association (2004) presents clear guidelines for medical staff working with all detainees (including prisoners, police detainees, asylum seekers), to ensure their healthcare needs are met. These include a thorough assessment of both physical and mental health at the start of the detention period, using external services as necessary if the problems presented are beyond the scope of staff and ensuring all staff working with healthcare professionals are aware of their role and duties. Throughout the EU, prison administrations follow international standards set by the WHO (HIPPP) guidelines, and the CPT¹⁸ regularly presents reports on a variety of detention facilities, with regards to conditions and treatment by staff.

Clear protocols and standards are necessary to ensure the human rights of prisoners are maintained and also allow for detainees to address concerns on the basis of treatment which does not adhere to such standards. The Council of Europe has developed rules for the care of prisoners in the EU, the purpose of which are to establish minimum standards for prison administrations; to serve as a ‘stimulus to prisons and administrations’ so they develop policies based on good practice and principles of equity; to encourage prison staff to adopt a professional attitude that reflects the ‘important social and moral qualities of their work’ and to provide conditions to optimise this and to provide realistic criteria for prison administrations and those responsible for inspecting prisons on which to base their judgements of performance and ‘measure progress towards higher standards’ (CPT, 1987).

5.10 Continuity of treatment

Prisoners should begin to be prepared for release on the day the sentence starts as part of the sentence planning process. All staff and NGOs available and working in prisons (see chapter 3.5) should be involved in preparing prisoners for release. Good release planning is particularly important for

18 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

drug-using prisoners. The risks of relapse and overdose are extremely high. Measures taken in prison to prepare drug-using prisoners for release include:

- implementing measures to achieve and maintain drug-free status after release,
- granting home leave and conditional release, integrated into treatment processes (e.g. antiretroviral treatment),
- cooperating with external drug services or doctors in planning a prisoner's release (e.g. continuation of OST in the community),
- involving self-help groups in the release phase,
- taking effective measures in prison to prevent prisoners from dying of a drug overdose shortly after release.

The challenge for prison services in facilitating a successful return to the community for prisoners without relapsing is not only to treat a drug problem but also to address other issues, including employability, educational deficits and maintaining family ties.

Aftercare

Several studies (e.g. Zurhold et al., 2005) show that effective aftercare for drug using prisoners is essential to maintain gains made in prison-based treatment. Nevertheless, prisoners often have difficulty in accessing assessments and paying for treatment on release under community care arrangements. The following conclusions are drawn from a multi-country survey on aftercare programmes for drug-using prisoners in several European countries (Fox, 2000):

- Aftercare for drug-using prisoners significantly decreases recidivism and relapse rates and saves lives.
- Interagency cooperation is essential for effective aftercare. Prisons, probation services, drug treatment agencies and health, employment and social welfare services must join to put the varied needs of drug-using offenders first.
- Drug treatment workers must have access to prisoners during their sentence to encourage participation in treatment and to plan release.
- Short-sentence prisoners are most poorly placed to receive aftercare and most likely to re-offend. These prisoners need to be fast-tracked into release planning and encouraged into treatment.
- Ex-offenders need choice in aftercare. One size does not fit all in drug treatment.

- Aftercare that is built into the last portion of a sentence appears to increase motivation and uptake.
- In aftercare, housing and employment should be partnered with treatment programmes. Unemployed and homeless ex-offenders are most likely to relapse and re-offend.

Working with families and maintaining family ties

The European Health Committee (established in 1954 by the Committee of Ministers of the Council of Europe) stated in 1995:

“One of the inevitable consequences of imprisonment is the temporary weakening of social contacts. It is true that family ties are not broken off completely, in the sense that in most cases a visit of at least one hour per week is permitted; nevertheless the prisoners’ relationships suffer enormously from the confinement. A large number of wives, husbands and children of detainees feel punished themselves to a similar extent as their convicted spouses and fathers. Besides, and worse still, in many cases the marriage is bound to fail or be ruined.”

Social contacts in general also suffer as a consequence of the imprisonment. In some countries such as Denmark and Switzerland, prisoners are given the opportunity to see their partners without supervision. Supervision is fairly relaxed in Sweden. Working with families of prisoners is a central part of rehabilitation and social reintegration in many countries. In some (such as Scotland, United Kingdom) special family contact development officers are employed to help families to keep or initiate contact with prisoners’ relatives, to help to work on relatives’ drug problems, to inform families about drug problems in prison and outside and to enhance family visits.

Throughcare

The drug strategy of HM Prison Service for England and Wales (United Kingdom Parliament, 1999) defines throughcare as follows: “By throughcare we mean the quality of care delivered to the offender from initial reception through to preparation for release establishing a smooth transition to community care after release”. The aims are as follows:

- to understand the pressures and fears affecting people’s judgement on entry to prison;
- to ease the transition process between the community and prison for drug users;

- to provide continuity, as far as possible, for those receiving treatment and support in the community on arrival in prison, on transferring between prisons and on returning to the community;
 - to recognize the opportunity that imprisonment offers to drug users to begin to deal with their drug misuse problem, particularly for those with no experience of community helping agencies;
 - to ensure that drug users have the opportunity of leaving prison in a better physical state, with a less chaotic lifestyle, than when they entered; and
 - to minimize the dangers of reduced tolerance levels on release from prison.
- (United Kingdom Parliament 1999, 15).

The Scottish Prison Service has general considerations required for through-care:

- good working relationships and clear lines of communication between prisons and external service agencies;
- drug workers using a partnership approach in prison with their clients;
- encouraging contacts between external agency and inmate; and
- maintaining continuity of care where possible, particularly for short-term prisoners.

Throughcare must involve multi-agency cooperation, which means intensive integration of external agencies that, at the time of release, will continue these efforts. The point of release is vital: how will the treatment work started in prison be continued on the outside, and have the treatment in prison and that available outside been coordinated? The phase of preparation for release should involve community based professional drug workers. After release, probation officers are involved in further treatment.

5.11 Opioid Substitution treatment (OST) in prisons

In order to meet the requirement that prisoners have access to the same treatments offered outside prison, prisoners falling into the following groups should be permitted to participate in methadone treatment in detention:

- those who had already started substitution treatment before imprisonment; and
- those who apply for participation in methadone treatment after incarceration, while in prison, and who meet the requirements for this treatment (Stöver/Weilandt, 2007).

Data from international studies show that some key elements have to be considered when starting substitution treatment (see also Kastelic, 2007; Kastelic et al. 2008):

- Continuity of care is required to maintain the benefits of methadone maintenance treatment.
- Maintenance treatment is more effective than detoxification programmes in promoting retention in drug treatment and abstinence from illicit drug use.
- information and education about the goals and treatment modalities and rules before substitution treatment is started.
- Adequate dosage (usually more than 60mg; see Stallwitz/Stöver, 2007).
- Acknowledging and integrating prisoner's experiences: Patients/prisoners involvement as valuable contributions to improve the quality of treatment and patient's satisfaction.
- Linkage with other treatments (HBV/HCV, HIV, STIs etc.).
- Reflecting and integrating womens' needs in designing and conducting substitution treatment (co-morbidity, polyvalent drug use, motherhood).

5.12 Needle exchange programmes in prisons

Despite the fact that the results of evaluations and practical experiences are encouraging, needle exchange programmes remain a somewhat exotic preventive measure within prisons (only available in about 65 prisons in 10 countries worldwide). In the prisons visited for this study, no needle exchange programme has been implemented, although high risk behaviour has been analysed. The resistance of staff members, politicians and trade unions against needle exchange programmes and harm reduction measures in general is blocking the introduction of successful HIV/AIDS and hepatitis preventive measures. Also prisoners expressed their resistance due to several reasons of fears regarding negative consequences of becoming known as 'addicts'. Syringe exchange schemes are still a hot political issue because they are supposed to symbolise the failure of keeping prisons 'drug free'. Needle exchange programmes are still subject to political decisions and strategies.

Successful models of a particular prison in a particular country cannot necessarily be transferred to another prison or country. The specific circumstances and needs of the prison as a consequence of a top-down process from political authorities have to be taken into account first when planning needle

exchange programmes. Based on the above experiences, a bottom-up process, initiated by the institution, and a top-down process as a reaction of the political authorities, seems to favour successful installation and outcome of a prison-based needle exchange programme.

One important lesson to be learned is that these measures are part of a broader health goal and should therefore be embedded in a global comprehensive prison-based drug and health promotion strategy. This process was part of the success of needle exchange programmes. To this end, additional harm reduction measures are discussed and some are being introduced in prison health care services in some countries. Despite these advances, prison based harm reduction measures are progressing slowly compared to the speed of the spread of infectious diseases (Stöver/Nelles, 2004).

6 Conclusions

This study gives a detailed picture of health status, drug use, health care and drug services in prison in Estonia, Hungary, Lithuania and Poland. Altogether 593 people were interviewed: 490 prisoners in the quantitative survey, 66 participants in prisoner focus groups, 27 experts working in prison and in NGOs (e.g. prison directors, doctors, nurses, social worker) and 10 experts from the Ministries of Justice and/or Prison Administration.

The results of this research are not representative. The prisoners involved were chosen mostly because of a drug use history, and this group is therefore over-represented in order to allow a deep insight into drug-related issues.

The majority of the sample (61.1%) serves a rather long prison sentence with more than three years, which is typical for these countries, and prison restrictions are perceived as distress.

The occupancy level is low in Lithuania (86.8 prisoners per 100 places) and Estonia (94.2), while in Hungary (118.5) and Poland (117.3) overcrowding is an issue, although the occupancy level may vary between the prisons in one country enormously. It became clear that general prison conditions like overcrowding affect the health status of prisoners and are posing serious problems to health care delivery in the sample prisons visited. Thus, reducing overcrowding is improving living, health and also working conditions for those who have to live and work in prisons. According to this study violence is a big issue in the prisons. 22.9% of the sample confirms the existence of sexual violence in prison, physical and psychological violence is reported by 50.0% and 66.7% respectively. This could be understood as connected to overcrowding on the one hand and the consumption of steroids and other drugs on the other hand.

The health status of prisoners is very heterogenous throughout the four countries studied. The spread of BBV infections varies greatly between countries: 18.7% of the whole sample of 490 inmates in the four countries report a HIV infection and 32.2% a HCV infection. While in Hungary almost nobody reported an infection with HIV or HCV, the proportion in the other three countries is up to 50% for HCV and 40% for HIV. In Estonia in general 14% of all prisoners are HIV positive. Regarding HCV no accurate overview is being elaborated until now, however, study results show that 30% of the prisoners are HBV-positive and 52% HCV-positive. In the majority of the

countries visited in this study, rates of drug users, drug injectors and BBV infections (HIV/HCV) in prison populations are much higher than those found in the general population outside of prisons, a fact primarily related to (injecting) drug use and to unsafe injection practices, both in the community and in prisons, and also to unprotected sexual contacts and tattooing in prisons.

Drug use is present in most prisons. For example in Estonia recent data provided by the Prison Department show that 28% of the male and more than 50% of the female prison population are considered to be drug addicts. In Lithuania the number of drug users in prison tripled in the last ten years from 6.6% in 1999 to 20.1% in 2009. According to members of the focus group in Lithuania approx. 50% of all prisoners are users of illegal drugs; “It is quite uncommon if somebody doesn’t use drugs”. On the other hand Hungary shows a low prevalence of drug users in prisons. However, also in Hungary on a local level data are indicating risk potential (at least in the Budapest Prison), where a recent study revealed that drug use before imprisonment has been stated by 58% of the respondents, daily use of benzodiazepines before by 29% and intravenous drug use before by 33%. In Poland one fifth of prison inmates was considered a drug user, a 2007 survey revealed high life time prevalence of drug use and 6.7 injecting drug use. The study shows that drug use takes place inside prison although to a lesser degree than outside. In Lithuania amphetamines is the most commonly used substance inside prison, while in Estonia benzodiazepines are more common, and the Hungarian sample reports only very little drug use.

The high prevalence of BBV infections in most of the prisons compared to community levels is in itself a massive threat for prison health care. On top of that risk behaviour, especially needle sharing, has been reported in many interviews. If heroin or home-made opioids etc. are used, the drugs are mainly taken intravenously, and up to 15 prisoners are sharing the needle. In Lithuania inmates estimate, that approx. 40 people share one syringe while staff estimates no more than 10 people share one syringe. Syringes are used until they are totally unusable; a new one would cost 6–9 packages of tobacco. Sharpening of the needle is done by using the window glass. Some prisoners describe the procedure: Those prisoners who are HIV-negative are boiling the needle for some minutes, the rest is sharing. According to the prisoners nobody cares for infections once the drugs are available. Their estimation about the spread of drug users is between 60–80%. Asked if there is a sharing of drugs and injection equipment, prisoners state that everybody

is sharing the same syringe as there is just one syringe available. Additional risk behaviour takes place in the prisons to a rather large extent; tattooing is reported by almost half the sample (47.4%), other behaviour is reported less often: sharing a razor blade by 12.5%, and body piercing by 9.1%.

The ‘Comprehensive Package for the prevention, treatment and care of HIV among IDUs’ provided by the WHO and UNODC – as a systematic reaction towards HIV epidemics – needs to be applied in all details in order to make a difference to the current mostly abstinence-oriented approaches (see WHO et al., 2009). The ‘Comprehensive Package’ includes nine interventions.

1. Needle and syringe programmes: In none of the prisons visited needle and syringe exchange programmes have been implemented or even discussed.

2. Opioid substitution treatment (OST) and other drug dependence treatment: Despite all efforts in the countries visited the reactions towards the high burden of health challenges need to be scaled up with more speed and intensity. The evidence-based drug intervention strategy of pharmacotherapy (OST) with methadone or other agents needs urgently to be either introduced or increased to reach a higher coverage. The majority of prisoners interviewed was in favour of an introduction of OST, especially for detoxification purposes. At the moment drug addicted opiate users entering prison experience severe withdrawal symptoms in the penal institutions. Often detoxification is not done state of the art, instead a symptomatic treatment is performed by using painkillers, benzodiazepines and sleeping pills. Furthermore prisoners interviewed are demanding “therapy instead of punishment”, which would allow them to get out of prisons earlier and go instead into therapeutic institutions.

3. HIV testing and counselling: Furthermore more attention has to be paid to the spread, prevention, screening, diagnostic and treatment of hepatitis B and C. Especially the policy and practice of HCV-tests and diagnosis need to be developed, HCV-testing should be recommended to all prisoners and should be part of the general medical examination on entrance. HCV-therapies – although expensive – have to be provided, as compliance of drug users to HCV therapies is comparable with other HCV-infected patient groups. In two of the countries (Hungary and Lithuania) HIV-positive prisoners are either separated or are sent to specialist prison centres for better control, monitoring and treatment. This might be problematic in terms of disclosing the HIV status and in Lithuania produces fears simply because of being transferred to a prison far off.

4. Antiretroviral treatment (ART): Antiretroviral treatment is implemented in the four countries, but not always offered to all those infected. Especially prisoners in ARV treatment often don't feel informed and educated about side effects. If the doctor is informing about ARV treatment often this is not understood correctly by the prisoners, who then need a 'translation'. According to prisoners the adherence to the therapies would be higher if patients would understand purpose and goal of the treatment. This partly leads to mistrust and a negative attitude towards prison health care.

5. Prevention and treatment of sexually transmitted infections: The prevention and treatment of sexually transmitted diseases (STIs) does not seem to be an important issue in the prisons visited.

6. Condom programmes: The provision of condoms is handled differently. Condoms are sometimes available at the prison shop, sometimes at the medical ward, and in some prisons condoms are only available in long term visit rooms. Usually condoms are not accessible in common areas for easy and confidential access.

7. Targeted information, education and communication (IEC): Information, communication, and education means and strategies have to be developed specifically for the different target groups in order to get the preventive messages and information across. Unspecific material and messages might get lost or do not have the impact expected.

8. Vaccination, diagnosis and treatment of viral hepatitis: HBV-vaccination is often offered only for members of risks groups (e.g. in Estonia for prisoners with more than seven months imprisonment). HCV treatment is offered in some cases.

9. Prevention, diagnosis and treatment of tuberculosis: Tuberculosis screening is done to a large extent in Hungarian and Polish sample prisons, where few prisoners refuse the test. It is offered as well in Lithuania and Estonia, especially to high-risk groups. TB-treatment is often done in the prison hospital.

In several countries special drug prevention units, drug free units and/or therapeutic wards have been installed. These units mostly are characterized by better living conditions and insofar are attractive for prisoners to apply for. Better living conditions thus are given as reward for abstaining from drugs. The Hungarian specialities are the drug prevention units in prisons, which build a frame and infrastructure for issuing hot topics and risk reduc-

tion messages. In general this strategy can also be seen as a step of a prison reform strategy, where health issues (drug use, infectious diseases) are demanding better living standards.

Measures to control drug use are mainly supply and to a lesser extent demand oriented. However, the acquisition of drugs in prison is perceived mainly as easy or very easy by 39.5% of the respondents (in Poland and Lithuania more than half the sample) and 60.5% said it's either very or rather difficult.

Both pharmacotherapy and abstinence-based approaches are important elements of pre-release treatment. Special approaches for women are needed as the spread of drug addiction and HIV is extremely high in this vulnerable population (see UNODC and WHO Europe, 2009; Van den Bergh et al., 2009). This has been confirmed by the fact that women do suffer more psychologically than men in two of the countries (Estonia, Poland), while in Hungary there is no difference and in Lithuania men report it more often. The women in the study are for example more often HIV-positive and have more often drug use experiences before incarceration than the men, which makes women an extremely vulnerable group.

Other future challenges are treatment forms for the increasing number of poly-drug users and sufficient prison-community linkages to establish sustainable pathways of throughcare.

This study aimed at looking at health problems and health care in general as it is perceived by staff and by prisoners. These are subjective views and do not claim representativeness. In several countries a discrepancy could be observed in the perceptions of prisoners and officials. Where prisoners are rating the quality of health care services with 20.6% very good or rather good, and 79.3% rating it rather bad or very bad, the professionals (doctors, nurses) often assess the quality of prison health care as partly higher than in the community, or as sufficient to meet the health care needs of prisoners. Also in the estimation of a specific behaviour (like drug use) the perceptions often differ widely, while a doctor may not see drug use as a major problem, this can be viewed quite oppositely by the prisoners (e.g. Lithuania). Both views of prisoners and staff are indicating the background of the discussion about health care delivery to prisoners. Prison staff compares the health care with that of the general population. This is problematic insofar, as there are mostly more serious and partly more massive health threats to be identified and treated in prisons than in the community (prevalence of drug dependence, mental, dental health problems, infectious diseases), which need special

attention if the principle of equivalence of health care should be installed in prisons. The main issue which is discussed by staff is that prisoners usually do not use and benefit from the health care system in the community to that degree as they do in prisons. Thus staff often expresses difficulties in understanding the health care demands of prisoners in the institution. This partly reflects general public attitudes towards the necessary (limited) scope and quality of health care delivery in prisons. In several countries visited the information policy regarding health care delivery, treatments is perceived by prisoners as insufficient or intransparent (e.g. provision of pills or ARV treatment).

In some countries more confidentiality of drug and health services has been demanded by prisoners. Especially psychological drug treatments are seen as problematic because prisoners fear that personal and confidential information could be disclosed. Even in self help groups like AA principles of openness and frankness are hard if at all to realize in prisons, because prisoners give detailed and sensitive information about themselves, which could be used against them. Participants of the AA groups often open up only shortly before they leave. Also confidentiality related to specific measures like provision of disinfectants is posing a problem. In Lithuania disinfectants are available in the 'living/leisure room' and are possibly being supervised by guards, so no prisoner would make use of this preventive measure. The lack of confidentiality might also be the reason for drug users not admitting that they are (former) drug users, because they fear negative consequences for their current sentence (e.g. separation, extra control etc.). Thus they cannot be contacted and motivated by drug services; many avoid official help contacts, they try to stay and get clean on their own. The background problem is stigmatisation of drug users as being 'Narkomans' (Lithuania). This term is leading to a completely negative attitude towards drug users and addicts and places these prisoners in the lowest level of the prison and societal hierarchy.

Therapy within the closed setting of a prison necessarily leads to problems of confidentiality, mistrust etc. External (NGOs) and not prison employees should offer this kind of psychological treatments.

Furthermore prison-based drug treatment should result in conditional release or continuing therapeutic efforts, at least these prisoners should be placed in a protected setting. If prisoners are being sent back to their wards or prisons they come from, this might endanger the achievements of therapy.

Growing expenditures for healthcare in prisons pose enormous threats due to the economic crisis and restricted budgets in the countries visited. However, extra investments are necessary to not increase the health costs in the community, which will have to be paid in the community health care after release from prison. The earlier diseases are treated the better are the chances of cure and healing. This subsequently leads to reduced costs.

Since the study was conducted in the four countries some developments have taken place and will continue to improve the prison conditions generally (buildings, overcrowding etc.) and the situation for drug using inmates (treatment options slowly increase, OST is started on low level in some prisons).

Research is lacking, especially on risk behaviour and longitudinal studies, which bring about more insight into the transition period from prisoner's return into the community. The long-term effects of interventions regarding sustainability are mostly unknown. This accounts especially for treatment units in Poland, more or less nothing is known about the sustainability of therapeutic effects. Research can also be increased or stimulated by close cooperations between prisons, prison administrations and medical or social scientific faculties in the cities close to prisons. If an interest can be evoked e.g. for medical or social scientific theses on these topics, then the insight into problems can be increased.

References

- Aerts, A., Hauer, B., Wanlin, M., Veen, J. (2006). Tuberculosis and tuberculosis control in European prisons. *Int J Tuberc Lung Dis* 10(11), 1215–1223.
- Airey, N., Marriott, J. (2003). Measuring therapeutic attitudes in the prison environment: development of the Prison Attitude to Drugs scale. *Addiction* 98(2), 179–184.
- Alarid, L.F., Marquart, J.W. (2009). Officer perceptions of risk of contracting HIV/AIDS in prison: A two-state comparison. *The Prison Journal* 89(4), 440–459.
- Amato-Gauci, A.J., Mimica, J., Murauskiene, L. (2006). Mid-Term Review of the Lithuanian National HIV/AIDS Prevention and Control Programme 2003–2008. UNDP, Vilnius.
- Anonymous (2002). Procedure on preventive examination for infections qualified as risky and of high risk of persons held in the institutions subordinate to the Prison Department under the Ministry of Justice approved by the joint order No343/191 of the Minister of Health Care of the Republic of Lithuania and the Minister of Justice of the Republic of Lithuania of 2 July 2002 In: M.o. Health, M.o. Justice (Eds.).
- Association of Alumni and Friends of the Law and Administration Faculty at the Jagellonian University (2009). Situation in Poland. Association of Alumni and Friends of the Law and Administration Faculty at the Jagellonian University, Krakow.
- Babudieri, et al. (2000). Directly observed therapy to treat HIV infection in prisoners. *JAMA* 284(2), 179–180.
- Ball, A., Kirkby, M., Williams, S., Bellomo, R., Goldsmith, D., Uchino, S., (1995). Multi-centre study on drug injecting and risk of HIV infection: a report prepared on behalf of the international collaborative group for World Health Organization programme on substance abuse, World Health Organization (WHO), Geneva.
- Bammann, K., Stöver, H. (Eds.), (2006). *Tätowierungen im Strafvollzug. Hafterfahrungen, die unter die Haut gehen*, BIS-Verlag, Oldenburg.
- Bauserman, R.L., Richardson, D., Ward, M., Shea, M., Bowlin, C., Tomoyasu, N., Solomon, L. (2003). HIV prevention with jail and prison

- inmates: Maryland's Prevention Case Management program. *AIDS Educ Prev* 15(5), 465–480.
- Belenko, S.R., Shedlin, M., Chaple, M. (2005). HIV risk behaviors, knowledge, and prevention service experiences among African American and other offenders. *Journal of Health Care for the Poor and Underserved* 16(4 Suppl B), 108–129.
- Betteridge, G., Jürgens, R., (2004). *Prisoners, HIV/AIDS, and Human Rights*. Montréal: Canadian HIV/AIDS Legal Network.
- Bird, A.G., Gore, S.M., Hutchinson, S.J., Lewis, S.C., Cameron, S., Burns, S. (1997). Harm reduction measures and injecting inside prison versus mandatory drugs testing: results of a cross sectional anonymous questionnaire survey. *The European Commission Network on HIV Infection and Hepatitis in Prison*. *Bmj* 315(7099), 21–24.
- Bird, S., Hutchinson, C. (2006). Mortality among Danish drug users released from prison. *International Journal of Prisoner Health*, 13–19.
- Bird, S., Hutchinson, S., Goldberg, D. (2003). Male drugs-related deaths in the fortnight after release from prison: Scotland, 1996–1999. *Addiction* 98(2), 185–190.
- Blaauw, E., Roesch, R., Kerkhof, A. (2000). Mental disorders in European prison systems: Arrangements for mentally disordered prisoners in the prison systems of 13 European countries. *International Journal of Law and Psychiatry* 23(5–6), 649–663.
- Bögemann, H. (2007). Promoting health and managing stress among prison employees. In: Møller, L., Stöver, H., Jürgens, R., Gatherer, A., Nikogosian, H. (Eds.), *Health in prisons A WHO guide to the essentials in prison health*. World Health Organization, Copenhagen.
- Bollini, P., Laporte, J.D., Harding, T.W. (2002). HIV prevention in prisons. Do international guidelines matter? *Eur J Public Health* 12(2), 83–89.
- Borkenstein, C. (1983). Urinkontrollen als unterstützende Maßnahmen von Abstinenzbemühungen im Justizvollzug. *Suchtgefahren* 29 (Suppl 1), 147–148.
- Borrill, J., Maden, A., Martin, A., Weaver, T., Stimson, G., Farrell, M., Barnes, T., Burnett, R., Miller, S., Briggs, D. (2003). Differential substance misuse treatment needs of women, ethnic minorities and young offenders in prison. Home Office, Online Report 33/03, London.

- Bundesministerium für Gesundheit (2003). Hepatitis. Verbesserung der Hepatitis-Prävention und Behandlung für Drogenabhängige. http://www.bmg.bund.de/nm_603372/SharedDocs/Publikationen/Drogen-und-Sucht/a-608,templateId=raw,property=publicationFile.pdf/a-608.pdf, accessed on 28.06.2008.
- Burdon, W.M., Messina, N.P., Prendergast, M.L. (2004). The California treatment expansion initiative: Aftercare participation, recidivism, and predictors of outcomes. *Prison Journal* 84(1), 61–80.
- Canadian HIV/AIDS Legal Network (2006). HIV/AIDS in Prisons in Central and Eastern Europe and the former Soviet Union. Bleach and other disinfectants (Info sheet 5). Montreal: The Network.
- Caplinskas, S., Likatavicius, G. (2002). Recent sharp rise in registered HIV infections in Lithuania. *Eurosurveillance Weekly* 6(26).
- Caplinskiene, I., Caplinskas, S., Griskevicius, A. (2003). [Narcotic abuse and HIV infection in prisons]. *Medicina (Kaunas)* 39(8), 797–803.
- CEEHRN, (2007). Hepatitis C prevention, treatment and care among injecting drug users in the new EU Member States and neighboring countries: situation, guidelines and recommendations.
- Chambers, M. (2010). The truth about drugs in prisons. *The Guardian*.
- Champion, J.K., Taylor, A., Hutchinson, S., Cameron, S., McMenamin, J., Mitchell, A., Goldberg, D. (2004). Incidence of hepatitis C virus infection and associated risk factors among Scottish prison inmates: a cohort study. *Am J Epidemiol* 159(5), 514–519.
- Chaplinskas, S., Griskevicius, A., Uzdaviniene, V., Kasperionas, V., Kuliesa, V., G., L., Dolan, K. (in press). Extensive HIC outbreak in a Lithuanian prison: 291 inmates infected with HIV.
- Commission of the European Communities (2007). Report from the Commission to the European Parliament and the Council: On the implementation of the Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence. Commission of the European Communities, 199 final, Brussels.
- Correctional Service Canada (1996). 1995 National Inmate Survey: Final Report. Correctional Research and Development (CSC), No SR-02, Ottawa.

- Correctional Service of Canada (2001). Research Report: Institutional Methadone Maintenance Treatment: Impact on Release Outcomes and Institutional Behaviour. Correctional Service of Canada Research Branch, Ottawa.
- Council of Europe (2004). Annual Penal Statistics SPACE I. [http:// www.coe.int/t/e/legal_affairs/legal_co-operation/prisons_and_alternatives/Statistics_SPACE_I/List_Space_I.asp](http://www.coe.int/t/e/legal_affairs/legal_co-operation/prisons_and_alternatives/Statistics_SPACE_I/List_Space_I.asp). accessed on 01.10.2007.
- Council of Europe (2007). Annual Penal Statistics. SPACE I. http://www.coe.int/t/e/legal_affairs/legal_co-operation/prisons_and_alternatives/statistics_space_i/List_Space_I.asp#TopOfPage. accessed on 05.06.2008.
- Coyle, A. (2007). Standards in prison health: The prisoner as a patient. In: Møller, L., Stöver, H., Jürgens, R., Gatherer, A., Nikogosian, H. (Eds.), *Health in prisons A WHO guide to the essentials in prison health*, 7–14.
- CPT (2006). Report to the Hungarian Government on the visit to Hungary carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 30 March to 8 April 2005. Council of Europe, Strasbourg. <http://www.cpt.coe.int/en/states/hun.htm>, accessed on 12.05.2010.
- Crow, I. (2006). *Resettling Prisoners: A Review*. The University of Sheffield, York.
- Daniels, A.M. (1997). Doctors in prison must be careful when prescribing methadone [comment]. *BMJ* 315(7108), 603.
- Darke, S., Kaye, S., Finlay-Jones, R. (1998). Drug use and injection risk-taking among prison methadone maintenance patients. *Addiction* 93(8), 1169–1175.
- De Groot, A.S., Dilorenzo, M., Sylla, M., Bick, J. (2006). Challenges and opportunities for HIV care in jails and prisons in the United States. *International Journal of Prisoner Health* 2(3), 173–191.
- Dean, J. (2005). The future of mandatory drug testing in Scottish prisons: A review of policy. *International Journal of Prisoner Health* 1(2–4), 163–170.
- Decorte, T. (2007). Problems, needs and service provision related to stimulant use in European prisons. *International Journal of Prisoner Health* 3(1), 29–42.

- van den Broek, A.N.G. (2000). Drug free units in the Netherlands: what did we learn in twenty years? In: Council of Europe (Ed.), *Drug-misusing offenders in prison and after release*. Council of Europe Publishing, Strasbourg. pp. 117–126.
- Department of Health (2006). *Clinical Management of Drug Dependence in the Adult Prison Setting. Including Psychosocial Treatment as a Core Part*. Department of Health, London.
- Dolan, K. (1999). *The epidemiology of hepatitis C infection in prison populations*. National Drug and Alcohol Research Centre.
- Dolan, K., Bijl, M., White, B. (2004). HIV education in a Siberian prison colony for drug dependent males. *International Journal of Equity in Health* 3, 7.
- Dolan, K., et al. (2003). A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug and Alcohol Dependence* 72, 59–65.
- Dolan, K., Hall, W., Wodak, A. (1996). Methadone maintenance reduces injecting in prison. *British Medical Journal* 312(7039), 1162.
- Dolan, K., Rutter, S., Wodak, A.D. (2003). Prison-based syringe exchange programmes: a review of international research and development. *Addiction* 98(2), 153–158.
- Dolan, K., Shearer, J., White, B., Wodak, A. (2002). *A randomised controlled trial of methadone maintenance treatment in NSW prisons*. National Drug and Alcohol Research Centre, Technical Report no 155, Sydney.
- Dolan, K., Wodak, A. (1999). HIV transmission in a prison system in an Australian State. *Medical Journal of Australia* 171(1), 14–17.
- Dolan, K., Wodak, A., Hall, W. (1998). Methadone maintenance treatment reduces heroin injection in NSW prisons. *Drug and Alcohol Review* 17(2), 153–158.
- Dole, V.P., Robinson, J., Orraga, J., Towns, E., Searcy, P., Caine, E. (1969). Methadone treatment of randomly selected criminal addicts. *N Engl J Med* 280(25), 1372–1375.
- Douglas, R.M., Gaughwin, M., Ali, R., Davies, L., Mylvaganam, A., Liew, C. (1989). Risk of transmission of the human immunodeficiency virus in the prison setting. *Medical Journal of Australia* 150.

- Drug Law and Health Policy Resource Network, (2002). Drug Policy and Health in Poland, Warsaw, Poland.
- Dumond, R.W., et al. (2006). Testimony Review Panel on Prison Rape California State Prison. www.ojp.usdoj.gov/reviewpanel/pdfs_nov06/written-dumond.pdf accessed on 14.10.2010.
- Edgar, K., O'Donnell, I. (1998). Mandatory Drug Testing in Prisons: The Relationship Between MDT and the Level and Nature of Drug Misuse. Home Office, Research Study 189, London.
- Elekes, Z., Kovacs, L. (2002). Old and new drug consumption habits in Hungary, Romania and Moldova. *Eur Addict Res* 8(4), 166–169.
- Elger, B.S. (2008). Towards equivalent health care of prisoners: European soft law and public health policy in Geneva. *J Public Health Policy* 29(2), 192–206.
- EMCDDA (2003). Treating drug users in prison – a critical area for health promotion and crime reduction policy. *Drugs in Focus*(7), 1–4.
- EMCDDA (2005). Annual Report 2005. The state of the drugs problem in Europe. EMCDDA, Lisbon.
- EMCDDA (2006). Annual report 2006. The state of the drug problem in the European Union. European Monitoring Centre for Drugs and Drug Addiction, Luxembourg.
- EMCDDA (2009). Health and social responses to drug use in prisons in the EU. European Monitoring Centre for Drugs and Drug Addiction.
- Estebanez Estebanez, P., Colomo Gomez, C., Zunzunegui Pastor, M.V., Rua Figueroa, M., Perez, M., Ortiz, C., Heras, P., Babin, F. (1990). Carceles y SIDA. Factores de riesgo de infeccion por el VIH en las carceles de Madrid [Jails and AIDS. Risk factors for HIV infection in the prisons of Madrid]. *Gaceta Sanitaria* 4(18), 100–105.
- Eurasian Harm Reduction Network (2009). The impact of drug policy on health and human rights in Eastern Europe: 10 years after the UN General Assembly Special Session on Drugs. Eurasian Harm Reduction Network (EHRN), Vilnius.
- Faber, M. (2008). Prevalence of hepatitis B/C, risk behavior, knowledge and attitudes among prisoners in Estonia – Preliminary results –. Workshop on HIV Prevention In Prison Settings Tallinn, Estonia.

- Farley, J., al., e. (2005). Hepatitis C treatment in a Canadian federal correctional population: Preliminary feasibility and outcomes. *International Journal of Prisoner Health* 1(1), 13–18.
- Farley, J., Vasdev, S., Fischer, B., Haydon, E., Rehm, J., Farley, T.A. (2005). Feasibility and outcome of HCV treatment in a Canadian federal prison population. *Am J Public Health* 95(10), 1737–1739.
- Farrell, M., Gowing, L., Marsden, J., Ling, W., Ali, R. (2005). Effectiveness of drug dependence treatment in HIV prevention. *International Journal of Drug Policy* 16, 67–75.
- Farrell, M., Strang, J., Stöver, H. (2010). Hepatitis B vaccination in prisons: a much-needed targeted universal intervention. *Addiction* 105(2), 189–190.
- Fazel, S., Bains, P., Doll, H. (2006). Substance abuse and dependence in prisoners: a systematic review. *Addiction* 101(2), 181–191.
- Fliegau, G. (2010a). Drug related facts, challenges and needs in the Hungarian Prison System. 2nd Connections Conference, London.
- Fliegau, G. (2010b). Personal Communication.
- Fried, M., Shiffman, M., Reddy, K., Smith, C., Marinos, G., al., e. (2002). Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. *N Engl J Med* 347, 975–982.
- Friedmann, P.D., Taxman, F.S., Henderson, C.E. (2007). Evidence-based treatment practices for drug-involved adults in the criminal justice system. *J Subst Abuse Treat* 32(3), 267–277.
- Garder, V., Kyzlasova, E., Kokotov, Y., Toichkina, T. (2009). Adherence to treatment of released prisoners in the Republic of Khakassia, Russian Federation. Poster presented at: Prison Health Protection, Madrid.
- Gaughwin, M., Douglas, R., Liew, C., Davies, L., Mylvaganam, A., Treffke, H., Edwards, J., Ali, R. (1991). HIV prevalence and risk behaviours for HIV transmission in South Australian prisons. *AIDS* 5, 845–851.
- Gerevich, J., Szabo, L., Polgár, P., Bácskai, E. (2006). Methadone Maintenance in Europe and Hungary: Degrees of sociocultural resistance. *Psychiatric Services* 57(6), 776–778.
- Gilbert, R.L., Costella, A., Piper, M., Gill, O.N. (2004a). Increasing hepatitis B vaccine coverage in prisons in England and Wales. *Commun Dis Public Health* 7(4), 306–311.

- Gilbert, R.L., O'Connor, T., Mathew, S., Allen, K., Piper, M., Gill, O.N. (2004b). Hepatitis A vaccination--a prison-based solution for a community-based outbreak? *Commun Dis Public Health* 7(4), 289–293.
- Glet, E. (2008). Evaluation eines Spritzentauschprogramms zur Prävention von HIV, Hepatitis B und C in der Justizvollzugsanstalt II am Hasenberge in Hamburg. Institut für Rechtsmedizin. Universität Hamburg, Hamburg.
- Goldberg, D., Taylor, A., McGregor, J., Davis, B., Wrench, J., Gruer, L. (1998). A lasting public health response to an outbreak of HIV infection in a Scottish prison? *Int J STD AIDS* 9(1), 25–30.
- Gonsior, T. (2000). Infektionsprophylaxe für Drogenabhängige in der Anstalt XII des offenen Vollzugs in Hamburg-Vierlande unter dem besonderen Aspekt des Spritzentausch-Angebots. Institut für Rechtsmedizin Universität Hamburg, Hamburg.
- Gordon, M.S., Kinlock, T.W., Schwartz, R.P., O'Grady, K.E. (2008). A randomized clinical trial of methadone maintenance for prisoners: findings at 6 months post-release. *Addiction* 103(8), 1333–1342.
- Gore, S.M., Bird, A.G. (1996). Cost implications of random mandatory drugs tests in prisons. *Lancet* 348(9035), 1124–1127.
- Gore, S.M., Bird, A.G., Ross, A. (1995). Prison rites: Starting to inject inside. *British Medical Journal* 311, 1135–1136.
- Gore, S.M., Bird, A.G., Ross, A.J. (1996). Prison rights: mandatory drugs tests and performance indicators for prisons. *Bmj* 312(7043), 1411–1413.
- Gray, A., Pearce, S., Marks, L. (2006). The training needs of doctors working in English and Welsh prisons: A survey of doctors. *International Journal of Prisoner Health* 2(2), 121–130.
- Gyarmathy, V.A., Neaigus, A., Szamado, S. (2003). HIV risk behaviour history of prison inmates in Hungary. *AIDS Education and Prevention* 15(6), 561–569.
- Haddad, W., Erkens, C. (2009). Coverage and yield of TB screening at entry in prisons in the Netherlands 1994–2007. Poster presented at: Prison Health Protection, Madrid.
- Hammerschick, W., Krucsay, B. (2007). Schritt für Schritt. Endbericht der Begleitforschung. Institut für Rechts- und Kriminalsoziologie, Wien.

- Harrison, L., Cappello, R., Alaszewski, A., Appleton, S., Cooke, G. (2003). The Effectiveness of Treatment for Substance Dependence within the Prison System in England: A review. University of Kent, Centre for Health Services Studies, Kent.
- Hassim, A. (2006). The '5 star' prison hotel. The right of access to ARV treatment for HIV positive prisoners in South Africa. *International Journal of Prisoner Health* 2(3), 157–172.
- Hayes, M.O., Harkness, G.A. (2001). Body piercing as a risk factor for viral hepatitis: an integrative research review. *American Journal on Infection Control* 29(4):271-4.
- Hayton, P. (2007). Protecting and promoting health in prisons: A settings approach. Møller, L., Stöver, H., Jürgens, R., Gatherer, A. & Nikogosian, H. (ed): *Health in prisons A WHO guide to the essentials in prison health*, 15–20.
- Heaps, M.M., Lurigio, A.J., Rodriguez, P., Lyons, T., Brookes, L. (2009). Recovery-oriented care for drug-abusing offenders. *Addict Sci Clin Pract* 5(1), 31–36.
- Hedrich, D., Carpentier, C. (2009). Prison and drugs in the European Union – focus on responses. *Connections Conference: Integrated responses to Drugs and Infectious across European Criminal Justice Systems*, Krakow.
- Heinemann, A., Bohlen, K., Püschel, K. (2002). Abstinenzorientierte Behandlungsstrategien im Strafvollzug. Evaluation des Abstinenz-Erprobungsprogramms in der JVA Vierlande in Hamburg. *Suchttherapie* 3, 146–154.
- Heinemann, A., Gross, U. (2001). Infektionsprophylaxe für Drogenkonsumenten im offenen Strafvollzug durch Vergabe steriler Einmalspritzen über Automaten. *Sucht* 47(1), 57–65.
- Heudtlass, J.H., Stöver, H. (1998). 'Harm reduction-Strategien' für intravenös applizierende Drogenkonsumenten und Bedienstete – auch im Strafvollzug. Ein Safer-use-Training Programm. *Wiener Zeitschrift für Suchtforschung* 21(1), 27–36.
- Holsen, D.S., Harthug, S., Myrmel, H. (1993). Prevalence of antibodies to hepatitis C virus and association with intravenous drug abuse and tattooing in a national prison in Norway. *European Journal of Clinical Microbiology and Infectious Diseases* 12(9), 673–676.

- Home Office Research Development and Statistics Directorate (2003). Prisoners' drug use and treatment: Seven research studies. <http://www.homeoffice.gov.uk/rds/pdfs2/r186.pdf>.
- Hope, V.D., Ncube, F., Hickman, M., Judd, A., Parry, J.V. (2007). Hepatitis B vaccine uptake among injecting drug users in England 1998 to 2004: is the prison vaccination programme driving recent improvements? *J Viral Hepat* 14(9), 653–660.
- Hughes, R.A. (2000a). Drug injectors and prison mandatory drug testing. *Howard Journal Of Criminal Justice* 39(1), 1–13.
- Hungarian National Focal Point (2009) . Annual Report.
- Hughes, R.A. (2000b). 'It's like having half a sugar when you were used to three' – drug injectors' views and experiences of substitute drug prescribing inside English prisons. *International Journal of Drug Policy* 10(6), 455–466.
- Hungarian Prison Headquarter (2008). Statistical Data on Prison in Hungary. Ministry of Justice, Budapest.
- Inciardi, J.A. (1996). HIV risk reduction and service delivery strategies in criminal justice settings. *J Subst Abuse Treat* 13(5), 421–428; discussion 439.
- Ionescu, C. (2009). The needle and syringe programs in Romanian penitentiary system. Case study: Jilava Penitentiary. Connections Conference: Integrated responses to Drugs and Infectious across European Criminal Justice Systems, Krakow.
- Jacob, J., Stöver, H. (1998). DrogenkonsumentInnen in Haft zwischen Hilfe, vollzoglicher Kontrolle und Eigenkompetenz. Zur Entwicklung einer 'Healthy Prisons'-Bewegung. *Wiener Zeitschrift für Suchtforschung* 21(2/3), 69–82.
- Jacobs, S. (1995). AIDS in correctional facilities: Current status of legal issues critical to policy development. *Journal of Criminal Justice* 23(3), 209–221.
- Johansons, M. (2000). Untersuchung über Konsumverhalten und Beikonsum von 389 mit Methadon substituierten Strafgefangenen in Hamburg. Institut für Rechtsmedizin. Universität Hamburg, Hamburg.
- Juodkaitė, D., Uscila, R., Stöver, H. (2008). Lithuanian legislation and policy analysis on HIV/AIDS prevention and care among injecting drug users

- in prison settings. Report to the UNODC regional project „HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania”. United Nations Development Programme in Lithuania, Vilnius. http://www.unodc.org/documents/baltics/Report_Legal_LT_ENG.pdf.
- Jürgens, R. (2004). HIV/AIDS in prisons. *Can HIV AIDS Policy Law Rev* 9(2), 45–52.
- Jürgens, R. (2006). HIV/AIDS and HCV in prisons: A select annotated bibliography (part 2). *International Journal of Prisoner Health* 2(2), 131–149.
- Jürgens, R., Ball, A., Verster, A. (2009). Interventions to reduce HIV transmission related to injecting drug use in prison. *The Lancet Infectious Diseases* 9(1), 57–66.
- Kastelic, A., Kostnapfel Rihtar, T. (2007). Agonist opioid treatment in prisons. *Heroin Addiction & Related Clinical Problems* 9(4), 21–30.
- Kaufmann, B., Dobler-Mikola, A., Uchtenhagen, A. (2001). Kontrollierte Opiatabgabe im Schweizerischen Strafvollzug. In: Jacob, J., Keppler, K., Stöver, H. (Eds.), *LebHaft: Gesundheitsförderung für Drogen Gebrauchende im Strafvollzug*. Deutsche AIDS-Hilfe, Berlin. pp. 127–132.
- Kendall, P.R., Pearce, M. (2000). Drug testing in Canadian jails: to what end? *Canadian Journal of Public Health* 91(1), 26–28.
- Kerr, T., Wood, E., Betteridge, G., Lines, R., Jürgens, R. (2004). Harm reduction in prisons: A 'rights based analysis'. *Critical Public Health* 14(4), 345–360.
- Kinlock, T.W., Gordon, M.S., Schwartz, R.P., O'Grady, K., Fitzgerald, T.T., Wilson, M. (2007). A randomized clinical trial of methadone maintenance for prisoners: Results at 1-month post-release. *Drug and Alcohol Dependence* 91(2–3), 220–227.
- Kinlock, T.W., Gordon, M.S., Schwartz, R.P., O'Grady, K.E. (2008). A Study of methadone maintenance for male prisoners: 3-month postrelease outcomes. *Criminal Justice and Behavior* 35(1), 34–47.
- Kinner, S.A. (2006). Continuity of health impairment and substance misuse among adult prisoners in Queensland, Australia. *International Journal of Prisoner Health* 2(2), 101–113.

- Kolind, T., Frank, V.A., Dahl, H. (2009). Drug treatment or alleviating the negative consequences of imprisonment? A critical view of prison-based drug treatment in Denmark. *Int J Drug Policy*.
- Krajewski, K. (2003). Drugs, markets and criminal justice in Poland. *Crime, Law & Social Change* 40(2–3), 273–293.
- Krajewski, K. (2009a). Drugs possession cases in courts in Krakow. *Connections Conference: Integrated responses to Drugs and Infectious across European Criminal Justice Systems*, Krakow.
- Krajewski, K. (2009b). Die weitere Entwicklung der Drogenpolitik in Polen oder eine symbolische Beschwörung der Wirklichkeit In: Pollähne, H., Stöver, H. (Eds.), *Komplemente In Sachen: Kriminologie, Drogenhilfe, Psychotherapie, Kriminalpolitik*. LIT Verlag, Münster. pp. 94–103.
- Krebs, C.P. (2006). Inmate factors associated with HIV transmission in prison. *Criminology & Public Policy* 5, 113–136.
- Krucsay, B. (2007). Bedürfnisse männlicher und weiblicher Strafgefangener vor und nach der Entlassung. Bericht zur Fragebogenerhebung im Rahmen des Projektes „Schritt für Schritt“. Institut für Rechts- und Kriminalsoziologie, Wien.
- Kuzmicz, E., Mielecka-Kubien, Z., Wiszejko-Wierzbička, D. (2009). Penalties for possession. Article 62 of the drug use prevention act – costs, time, opinions. Instytut Spraw Publicznych, Warsaw.
- Lagerspetz, M., Moskalewicz, J. (2002). Drugs in the postsocialist transitions of Estonia, Latvia, Lithuania and Poland. *European Addiction Research* 8(4), 177–183.
- Langan, N.P., Pelissier, B.M. (2001). Gender differences among prisoners in drug treatment. *Journal of Substance Abuse* 13(3), 291–301.
- Larney, S. (2010). Does opioid substitution treatment in prisons reduce injecting-related HIV risk behaviours? A systematic review. *Addiction* 105(2), 216–223.
- Larney, S., Dolan, K. (2009). A literature review of international implementation of opioid substitution treatment in prisons: equivalence of care? *Eur Addict Res* 15(2), 107–112.
- Laticevski, D. (2007). Communicable diseases. In: Møller, L., Stöver, H., Jürgens, R., Gatherer, A., Nikogosian, H. (Eds.), *Health in prisons. A WHO guide to the essentials in prison health*. WHO, Copenhagen. 43–59.

- Lenton, S. (2003). Policy from a harm reduction perspective. *Current Opinion in Psychiatry* 16(3), 271–277.
- Leukefeld, C., Oser, C.B., Havens, J., Staton Tindall, M., Mooney, J., Duvall, J.B., Knudsen, H. (2009). Drug abuse treatment beyond prison walls. *Addict Sci Clin Pract* 5(1), 24–30.
- Levasseur, L., Marzo, J.N., Ross, N., Blatier, C. (2002). Fréquence des ré-incarcérations dans une même maison d'arrêt: Rôle des traitements de substitution. *Ann Med Interne (Paris)* 153(3 Suppl), 1S14–19.
- Lewis, C. (2006). Treating incarcerated women: gender matters. *Psychiatric Clinics of North America* 29(3), 773–789.
- Liddicoat, R.V., Zheng, H., Internicola, J., Werner, B.G., Kazianis, A., Golan, Y., Rubinstein, E.P., Freedberg, K.A., Walensky, R.P. (2006). Implementing a routine, voluntary HIV testing program in a Massachusetts county prison. *J Urban Health* 83(6), 1127–1131.
- Lind, B., Chen, S., Weatherburn, D., Mattick, R. (2004). The effectiveness of methadone maintenance treatment in controlling crime: an aggregate-level analysis. NSW Bureau for Crime Statistics and Justice.
- Lines, R. (2006). From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons. *The International Journal of Prisoner Health* 2(4), 269–280.
- Lines, R. (2008). The right to health of prisoners in international human rights law. *International Journal of Prisoner Health* 4(1), 3–53.
- Lines, R., Jürgens, R., Betteridge, G., Stöver, H. (2005a). Taking action to reduce injecting drug-related harms in prisons: The evidence of effectiveness of prison needle exchange in six countries. *International Journal of Prisoner Health* 1(1), 49–64.
- Lines, R., Jürgens, R., Betteridge, G., Stöver, H., Laticevschi, D., Nelles, J., (2006). Prison Needle Exchange: Lessons from A Comprehensive Review of International Evidence and Experience. 2., Canadian HIV/AIDS Legal Network, Montreal.
- Lines, R., Jürgens, R., Stöver, H., Kaliakbarova, G., Laticevschi, D., Nelles, J., MacDonald, M., Curtis, M. (2004). Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia. Prison health is public

- health. Irish Penal Reform Trust, Dublin. <http://www.iprt.ie/contents/287>, accessed on 12.09.2010.
- Lines, R., Jürgens, R., Stöver, H., Kaliakbarova, G., Laticevschi, D., Nelles, J., MacDonald, M., Curtis, M. (2005b). The Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia. Good prison health is good public health. Dublin, Ireland, February 23, 2004. *International Journal of Prisoner Health* 1(1), 91–98.
- Lines, R., Stöver, H. (2006). Building an effective international framework to address HIV/AIDS in prisons. *International Journal of Prisoner Health* 2(3), 237–242.
- Lines, R., Stöver, H., Donoghoe, M.C., Lazarus, J.V. (2009). Monitoring harm reduction in European prisons via the Dublin Declaration. *International Journal of Prisoner Health* 4(5), 251–255.
- Lodewijks, H. (2006). Brains 4 Use. An addiction programme for youth in a juvenile justice institution. Treatment of Rentray, Netherlands.
- Long, J. (2003). Prevalence of and risk factors for blood-borne viruses among prison inmates and entrants in Ireland: an overview. HIV, Hepatitis C, and Harm Reduction in Prisons: Evidence, Best Practice and Human Rights, Dublin, Ireland.
- MacDonald, M. (2001). Prison Health Care in the Czech Republic, Hungary and Poland. The European Institute for Crime Prevention and Control, affiliated with the United Nations. Heuni Paper No 16, Helsinki.
- MacDonald, M. (2003). A Comparative Report of Health Care Provisions in Prisons in Poland, Hungary and the Czech Republic. The European Institute for Crime Prevention and Control, affiliated with the United Nations. HEUNI Paper No. 19, Helsinki.
- MacDonald, M. (2004). A Study of Existing Drug Services and Strategies Operating in Prisons in Ten Countries from Central and Eastern Europe. Central and Eastern European Network of Drug Services in Prison (CEENDPS). Cranstoun drug services, Warsaw.
- MacDonald, M. (2005). A Study of Health Care Provision, Existing Drug Services and Strategies Operating in Prisons in Ten Countries from Central and Eastern Europe. Heuni, Finland. www.heuni.fi/12542.htm.

- MacDonald, M. (2006). People with problematic drug use and HIV/AIDS in European prisons: An issue of patient confidentiality. *International Journal of Prisoner Health* 2(3), 207–218.
- MacDonald, M., Atherton, S., Stöver, H. (2007). Juveniles in Secure Settings: Services for problematic drug and alcohol users. European Network on drugs and infectious prevention in prison (ENDIPP) and Cranstoun Drug Services, London, Brussels.
- MacDonald, M., Harvey, L. (1997). Mandatory drug testing in prisons. Centre for Research into Quality, University of Central England, Birmingham. <http://www0.bcu.ac.uk/crq/publications/mdt.pdf>, accessed on 18.10.2007.
- Magura, S., Rosenblum, A., Lewis, C., Joseph, H. (1993). The effectiveness of in-jail methadone-maintenance. *Journal of Drug Issues* 23(1), 75–99.
- Malliori, M., Sypsa, V., Psychogiou, M., Touloumi, G., Skoutelis, A., Tsapopoulos, N., Hatzakis, A., Stefanis, C. (1998). A survey of bloodborne viruses and associated risk behaviours in Greek prisons. *Addiction* 93(2), 243–251.
- Marshall, T., Simpson, S., Stevens, A. (1999). Alcohol and drug misuse. Department of Public Health and Epidemiology, University of Birmingham, Birmingham.
- Marzo, J.N., Rotily, M., Meroueh, F., Varastet, M., Hunault, C., Obradovic, I., Zin, A. (2009). Maintenance therapy and 3-year outcome of opioid-dependent prisoners: a prospective study in France (2003–06). *Addiction* 104(7), 1233–1240.
- Masia, M., Achermann, C., Richter, M., Hostettler, U. (2007). Auswertungsbericht zur Fragebogenerhebung: „Analyse von Präventionsmassnahmen und Behandlungsangeboten von Infektionskrankheiten und Drogenabhängigkeit in Schweizer Anstalten des Freiheitsentzugs“. Universität Freiburg. Department Sozialarbeit und Sozialpolitik, Fribourg.
- Mertz, K.J., Schwebke, J.R., Gaydos, C.A., Beidinger, H.A., Tulloch, S.D., Levine, W.C. (2002). Screening women in jails for chlamydial and gonococcal infection using urine tests: feasibility, acceptability, prevalence, and treatment rates. *Sexually Transmitted Diseases* 29(5), 271–276.
- Metz, V., Matzenauer, C., Kammerer, K., Winklbaaur, B., Ebner, N., Radler, D., Fischer, G. (2010). Evaluation of opioid-dependent prisoners inoral

- opioid maintenance therapy. *Heroin Addiction & Related Clinical Problems* 12(1).
- Meyenberg, R., Stöver, H., Jacob, J., Pospeschill, M., (1999). *Infektionsprophylaxe im Niedersächsischen Justizvollzug*, BIS-Verlag, Oldenburg.
- Michel, L., Carrieri, M.P., Wodak, A. (2008). Harm reduction and equity of access to care for French prisoners: a review. *Harm Reduction Journal* 5(17).
- Michel, L., Maguet, O. (2003). *L'organisation des soins en matière de traitements de substitution en milieu carcéral. Rapport pour la Commission nationale consultative des traitements de substitution*. Paris: Centre Régional d'Information et de Prévention du Sida Ile-de-France.
- Michel, L., Maguet, O. (2005). *Traitements de substitution en milieu carcéral: guide des bonnes pratiques [Guidelines for substitution treatments in prison populations]*. *Encephale* 31(1), 92–97.
- Michels, II, Stöver, H., Gerlach, R. (2007). Substitution treatment for opioid addicts in Germany. *Harm Reduct J* 4, 5.
- Minc, A., Butler, T., Gahan, G. (2007). The Jailbreak Health Project--incorporating a unique radio programme for prisoners. *Int J Drug Policy* 18(5), 444–446.
- Modi, A., Baldwin, J., Orlans, M., Dodds, G., Marsh, G., Bothra, V., Chaloner, J. (2009). Monitoring vaccination coverage and uptake in a youth offender institution: Our achievements and the way forward. Poster at: *Prison Health Protection What works in the prevention and control of major communicable diseases*, Madrid.
- Møller, L., Stöver, H., Jürgens., R., Gatherer, A., Nikogolian, H. (2007). *Health in prisons A WHO guide to the essentials in prison health*. WHO, Copenhagen.
- Muncie, J. (2005). The globalisation of crime control: the case of youth and juvenile justice. *Theoretical Criminology* 9(1), 35–64.
- National Institute for Health Development, Estonian Drug Monitoring Centre/REITOX National Focal Point (2008). *National report (2007 data) to the EMCDDA by the Reitox National Focal Point "Estonia"*. New Development, Trends and In-depth Information on Selected Issues. EMCDDA.

- National Treatment Agency for Substance Misuse (2005). Consultation report. Models of care for the treatment of adult drug misusers.
- Neff, M.J. (2003). CDC updates guidelines for prevention and control of infections with hepatitis viruses in correctional settings. *American Family Physician* 67, 2620–2622.
- Nelles, J., Stöver, H. (2002). Zehn Jahre Spritzenvergabe im Gefängnis: Ein Review der bisherigen Spritzenvergabeprojekte in der Schweiz, Deutschland, Spanien und Moldawien. *Suchttherapie* 3, 155–161.
- Nyk, A. (2009). Continuity of care and effectiveness within the Criminal Justice System. Connections Conference: Integrated responses to Drugs and Infectious across European Criminal Justice Systems, Krakow.
- Okie, S. (2007). Sex, Drugs Prisons, and HIV. *The New England Journal of Medicine* 365, 105–108.
- Pallas, J.R., Farinas-Alvarez, C., Prieto, D., Delgado-Rodriguez, M. (1999). Coinfections by HIV, hepatitis B and hepatitis C in imprisoned injecting drug users. *European Journal of Epidemiology* 15(8), 699–704.
- Payne-James, J.J., Wall, I.J., Bailey, C. (2005). Patterns of illicit drug use of prisoners in police custody in London, UK. *J Clin Forensic Med* 12(4), 196–198.
- Pearson, F.S., Lipton, D.S. (1999). A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse. *The Prison Journal* 79(4), 384–410.
- Pelissier, B., Jones, N. (2006). Differences in motivation, coping style, and self-efficacy among incarcerated male and female drug users. *Journal of Substance Abuse Treatment* 30(2), 113–120.
- Pelissier, B., Jones, N., Cadigan, T. (2007). Drug treatment aftercare in the criminal justice system: a systematic review. *Journal of Substance Abuse Treatment* 32(3), 311–320.
- Pelissier, B., Motivans, M., Rounds-Bryant, J.L. (2005). Substance Abuse Treatment Outcomes: A Multi-Site Study of Male and Female Prison Programs. *Journal of Offender Rehabilitation* 41(2), 57–80.
- Polish Department of Justice, B.o.S. (2009). Penitentiary system in Poland – Statistics. Polish Department of Justice, Bureau of Statistics.

- Polonsky, S., Kerr, S., Harris, B., Gaiter, J., Fichtner, R.R., Kennedy, M.G. (1994). HIV prevention in prisons and jails: obstacles and opportunities. *Public Health Report* 109(5), 615–625.
- Pont, J. (2006). Medical ethics in prisons: rules, standards and challenges. *International Journal of Prisoner Health* 2(4), 259–267.
- Pontali, E. (2005). Antiretroviral treatment in correctional facilities. *HIV Clinical Trials* 6(1), 25–37.
- Porporino, F.J., Robinson, D., Millson, B., Weekes, J.R. (2002). An outcome evaluation of prison-based treatment programming for substance users. *Subst Use Misuse* 37(8–10), 1047–1077.
- Post, J., Dolan, K.A., Whybin, L.R., Carter, I.W., Haber, P.S., Lloyd, A.R. (2001). Acute hepatitis C virus infection in an Australian prison inmate: tattooing as a possible transmission route. *Medical Journal of Australia* 174(4), 183–184.
- Prendergast, M.L. (2009). Interventions to promote successful re-entry among drug-abusing parolees. *Addiction Science & Clinical Practice* 5(1), 4–13.
- Prendergast, M.L., Hall, E.A., Wexler, H.K., Melnick, G., Cao, Y. (2004). Amity prison-based therapeutic community: 5-year outcomes. *Prison Journal* 84(1), 36–60.
- Quaker Council for European Affairs (2007). The European prison rules: A gender critique. Country Report: Estonia. Quaker Council for European Affairs, Women in prison project, Bruxelles.
- Radun, D., et al. (2007). Cross-sectional study on seroprevalence regarding hep b, hep c and hiv, risk behaviour, knowledge and attitudes about bloodborne infections among adult prisoners in Germany – Preliminary Results. Abstract. European Scientific Conference on Applied Infectious Disease Epidemiology – ESCAIDE –, Stockholm, Sweden.
- Ramsay, M. (2003). Prisoners’ drug use and treatment: Seven Studies. Home Office, Findings 186, London.
- Rehman, L., Gahagan, J., DiCenso, A.M., Dias, G. (2004). Harm reduction and women in the Canadian national prison system: policy or practice? *Women Health* 40(4), 57–73.
- Reitox National Focal Point Hungary (2006). National Report to the EMCDDA by the REITOX National Focal Point 2006. Hungary. New Developments, Trends and In-Depth Information on Selected Topics.

- Reitox National Focal Point Hungary (2007). National Report to the EMCDDA by the REITOX National Focal Point 2007. Hungary. New Developments, Trends and In-Depth Information on Selected Topics.
- Reitox National Focal Point Hungary (2008). National Report to the EMCDDA by the REITOX National Focal Point 2008. Hungary. New Developments, Trends and In-Depth Information on Selected Topics.
- Reitox National Focal Point Hungary (2009). National Report to the EMCDDA by the REITOX National Focal Point 2008. Hungary. New Developments, Trends and In-Depth Information on Selected Topics.
- Reitox National Focal Point Lithuania (2007). National Report to the EMCDDA. Lithuania. New Developments, Trends and In-Depth Information on Selected Topics. EMCDDA.
- Reitox National Focal Point Lithuania (2008). National Report to the EMCDDA. Lithuania. New Developments, Trends and In-Depth Information on Selected Topics. EMCDDA.
- Reitox National Focal Point Poland (2007). 2007 National report (2006 data) to the EMCDDA. New Development, Trends and In-depth information on selected issues. EMCDDA.
- Reitox National Focal Point Poland (2008). National Report to the EMCDDA. Poland. New Developments, Trends and In-Depth Information on Selected Topics. EMCDDA.
- Remy, A.J., Serraf, L., Galinier, A., Hedouin, V., Gosset, D., Wagner, P. (2006). Treatment for hepatitis C in jailhouses is doable and successful: Definitive data of first national French study (POPHEC). *Heroin Addiction & Related Clinical Problems* 8(2), 47–49.
- Restellini, J.-P. (2007). Prison-specific ethical and clinical problems. In: Møller, L., Stöver, H., Jürgens., R., Gatherer, A., Nikogosian, H. (Eds.), *Health in prisons A WHO guide to the essentials in prison health*. WHO, Copenhagen. pp. 33–42.
- Roberts, A.J., Hayes, A.J., Carlisle, J., Shaw, J. (2007). *Review of Drug and Alcohol Treatments in Prison and Community Settings. A systematic review conducted on the behalf of the Prison Health Research Network*. Prison Health Research Network, Department of Health, England.

- Rosen, P.J., Hiller, M.L., Webster, J., Staton, M., Leukefeld, C. (2004). Treatment Motivation and Therapeutic Engagement in Prison-Based Substance Use Treatment. *Journal of Psychoactive Drugs* 36(3), 387–396.
- Rotily, M., Weilandt, C. (1999). European Network on HIV/AIDS and Hepatitis Prevention in Prisons – 3rd annual report. Observatoire Regional de la Santé Provence, Alpes, Cote d'Azur, Marseille; Wissenschaftliches Institut für die Ärzte Deutschlands, Bonn; Hartmannbund, Bonn.
- Rutter, S., Dolan, K., Wodak, A., Heilpern, H. (2001). Prison-Based Syringe Exchange Programs. A Review of International Research and Program Development National Drug and Alcohol Research Centre, University of New South Wales, NDARC Technical Report No. 112, Sydney.
- Samuel, M.C., Doherty, P.M., Bulterys, M., Jenison, S.A. (2001). Association between heroin use, needle sharing and tattoos received in prison with hepatitis B and C positivity among street-recruited injecting drug users in New Mexico, USA. *Epidemiology and Infection* 127(3), 475–484.
- Schulte, B., Stöver, H., Thane, K., Schreiter, C., Gansefort, D., Reimer, J. (2009). Substitution treatment and HCV/HIV-infection in a sample of 31 German prisons for sentenced inmates. *International Journal of Prisoner Health* 5(1), 39–44.
- Seal, D.W., Belcher, L., Morrow, K., Eldridge, G., Binson, D., Kacaneck, D., Margolis, A.D., McAuliffe, T., Simms, R. (2004). A qualitative study of substance use and sexual behavior among 18- to 29-year-old men while incarcerated in the United States. *Health Education & Behavior* 31(6), 775–789.
- Semenaite, B. (2009). The Lithuanian Prisons System. MEDICAL DIVISION OF PRISON DEPARTMENT AT THE MINISTRY OF JUSTICE OF THE REPUBLIC OF LITHUANIA, Vilnius.
- Semenaite, B., Januleviciene, R., Kežys, G., Cepulis, R., Rapcevic, E., Ilevicius, V., Braam, R. (2008). Rapid assessment and response on drug use in Marijampole correction house, Lithuania. UNODC, Prison Department at the Ministry of Justice of the Republic of Lithuania, Vilnius.
- Shah, S.M., Shapshak, P., Rivers, J.E., Stewart, R.V., Weatherby, N.L., Xin, K.Q., Page, J.B., Chitwood, D.D., Mash, D.C., Vlahov, D., McCoy, C.D. (1996). Detection of HIV-1 DNA in needle/syringes, paraphernalia, and washes from shooting galleries in Miami: a preliminary labo-

- ratory report. *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology* 11(3), 301–306.
- Shapshak, P., Fujimura, R.K., Page, J.B., Segal, D., Rivers, J.E., Yang, J., Shah, S.M., Graham, G., Metsch, L., Weatherby, N., Chitwood, D.D., McCoy, C.B. (2000). HIV-1 RNA load in needles/syringes from shooting galleries in Miami: a preliminary laboratory report. *Journal of Drug and Alcohol Dependency* 58(1–2), 153–157.
- Shearer, J., Wodak, A., Dolan, K. (2007). Evaluation of a prison-based naltrexone program. *International Journal of Prisoner Health* 3(3), 214–224.
- Shewan, D., Macpherson, A., Reid, M.M., Davies, J.B. (1996). The impact of the Edinburgh Prison Drug Reduction Programme. *Legal and Criminological Psychology* 1(1), 83–94.
- Shewan, D., Stöver, H., Dolan, K. (2005). Injecting in prisons. In: Pates, R., McBride, A., Arnold, K. (Eds.), *Injecting illicit drugs*. Blackwell, Oxford. pp. 69–81.
- Singleton, N., Pendry, E., Taylor, C., Farrell, M., Marsden, J. (2003). Drug-related mortality among newly released offenders. Home Office, Findings 187, London.
- Smith, L.A., Gates, S., Foxcroft, D. (2007). Therapeutic communities for substance related disorder. *Cochrane Database Syst Rev*(1), CD005338.
- Sorbello, L., Eccleston, L., Ward, T. (2002). Treatment needs of female offenders: A review. *Australian Psychologist* 37(3), 198–205.
- Soto Blanco, J.M., Perez, I.R., March, J.C. (2005). Adherence to antiretroviral therapy among HIV-infected prison inmates (Spain). *Int J STD AIDS* 16(2), 133–138.
- Spirig, H., et al. (1999). Country Report of Austria. European ENDP-Network on the prevention of infectious diseases.
- Stallwitz, A., Stöver, H. (2007). The impact of substitution treatment in prisons – a literature review. *International Journal of Drug Policy* 18, 464–474.
- Stankuviene, R. (2009). Panevezys prison.
- Stark, K., Herrmann, U., Ehrhardt, S., Bienzle, U. (2001). Modellprojekt Spritzenvergabe im Berliner Justizvollzug. Abschlussbericht der Begleitforschung, Berlin.

- Stark, K., Herrmann, U., Ehrhardt, S., Bienzle, U. (2006). A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany. *Epidemiol Infect* 134(4), 814–819.
- Stöver, H. (2001). An overview study: assistance to drug users in European Union prisons. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon.
- Stöver, H. (2002). DrogengebraucherInnen und Drogenhilfe im Justizvollzug – eine Übersicht. *Suchttherapie* 3, 135–145.
- Stöver, H. (2003). 10 years of syringe provision to intravenous drug users in prisons – an end to the projects in Germany. *Connections The newsletter of the European network drug services in prison & Central and Eastern European network drug services in prison*(13), 12–14.
- Stöver, H. (2008). Evaluation of national responses to HIV/AIDS in prison settings in Estonia. Evaluation carried out on behalf of the UNODC Regional project “HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania”. UNODC. http://www.unodc.org/documents/baltics/Report_Evaluation_Prisons_2_008_Estonia.pdf.
- Stöver, H., Casselman, J., Hennebel, L. (2006). Substitution treatment in European prisons: A study of policies and practices in 18 European countries. *International Journal of Prisoner Health* 2(1), 3–12.
- Stöver, H., Hennebel, L., Casselman, J. (2004). Substitution Treatment in European Prisons. A study of policies and practices of substitution treatment in prisons in 18 European countries. Cranstoun drug services, London.
- Stöver, H., Lines, R. (2006). Silence Still = Death. 25 years of HIV/AIDS in Prisons. 25-Years of HIV/AIDS in Europe. In: Matic, S., Lazarus, J.V., Donoghoe, M.C. (Eds.), *HIV/AIDS in Europe Moving from death sentence to chronic disease management*. WHO – Regional Office for Europe pp. 67–85.
- Stöver, H., Nelles, J. (2003). Ten years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies. *International Journal of Drug Policy* 14(5–6), 437–444.
- Stöver, H., Trautmann, F. (2001). Risk Reduction for Drug Users in Prisons. 'Encouraging Health Promotion For Drug Users Within The Criminal Justice System'. Trimbos-Instituut, Utrecht.

- Stöver, H., Weilandt, C. (2007). Drug use and drug services in prisons. In: Møller, L., Stöver, H., Jürgens., R., Gatherer, A., Nikogosian, H. (Eds.), Health in prisons A WHO guide to the essentials in prison health. WHO, Copenhagen. pp. 85–112.
- Stöver, H., Weilandt, C., Zurhold, H., Hartwig, C., Thane, K. (2007). The status-quo of prevention, treatment and harm reduction services for people in prisons and in reintegration services for persons on release from prisons. Universität Bremen, Wissenschaftliches Institut der Ärzte Deutschlands gem. e.V., Zentrum für Interdisziplinäre Suchtforschung der Universität Hamburg.
- Stöver, H., Weilandt, C., Zurhold, H., Hartwig, C., Thane, K. (2008). Final Report on Prevention, Treatment, and Harm Reduction Services in Prison, on Reintegration Services on Release from Prison and Methods to Monitor/Analyse Drug use among Prisoners. European Commission, Directorate – General for health and Consumers. Drug policy and harm reduction. SANCO/2006/C4/02. http://ec.europa.eu/health/ph_determinants/life_style/drug/documents/drug_frep1.pdf, accessed on 23.4.2009.
- Strang, J., Pilling, S., Albert, E.R., Brothie, J., Copello, A., Drummond, C., Gilman, M., Hopkins, S., Jones, C., King, R., Leighton, T., Li, R., Mavranouzouli, I., McDermott, P., Meader, N., Sood, P., Stockton, S., Stopher, A., Taylor, C., Wardle, I., Williams, T., Wright, N. (2007). Drug misuse. Psychosocial management of drug misuse. National Clinical Practice Guideline Number X. Draft for consultation. National Collaborating Centre for Mental Health. National Institute for Health and Clinical Excellence.
- Subata, E., Rotberga, S. (2009). Report from visit to Tartu prison by Dr. Emilis Subata, Vilnius Centre for Addictive Disorders, Lithuania, and Signe Rotberga, UNODC, Baltic. UNODC.
- Sutton, A.J., Gay, N.J., Edmunds, W.J. (2006). Modelling the impact of prison vaccination on hepatitis B transmission within the injecting drug user population of England and Wales. *Vaccine* 24(13), 2377–2386.
- Takács, I.G. (2009a). Personal communication. Budapest.
- Takács, I.G. (2009b). Risk behaviours for drug related and sexually transmitted infections in Hungarian Prisons. Connections Conference: Integrated responses to Drugs and Infectious across European Criminal Justice Systems, Krakow.

- Tarvis, H. (2008). *Convictus Estonia*. Convictus Estonia, Tallin.
- Taylor, A., Goldberg, D. (1996). Outbreak of HIV infection in a Scottish prison: why did it happen? *Canadian HIV/AIDS Policy & Law Newsletter* 2(3), 13–14.
- Taylor, A., Goldberg, D., Emslie, J., Wrench, J., Gruer, L., Cameron, S., Black, J., Davis, B., McGregor, J., Follett, E., Harvey, J., Basson, J., McGavigan, J. (1995). Outbreak of HIV infection in a Scottish prison. *British Medical Journal* 310(6975), 289–292.
- The Patel Report, Prison Drug Treatment Strategy Review Group (2010). *Reducing Drug-Related Crime and Rehabilitating Offenders Recovery and rehabilitation for drug users in prison and on release: recommendations for action*.
- Thompson, S.C., Hernberger, F., Wale, E., Crofts, N. (1996). Hepatitis C transmission through tattooing: a case report. *Australia and New Zealand Journal of Public Health* 20(3), 317–318.
- Turnbull, P.J., Dolan, K.A., Stimson, G.V. (1991). *Prisons, HIV and Aids: Risks and Experiences in custodial care*.
- Turnbull, P.J., McSweeney, T. (2000). Drug treatment in prison and after-care: a literature review and results of a survey of European countries. In: Council of Europe (Ed.), *Drug-misusing offenders in prison and after release*. Council of Europe Publishing, Strasbourg. pp. 41–59.
- Turnbull, P.J., Webster, R. (1998). Demand Reduction Activities in the Criminal Justice System in the European Union. *Drugs: education, prevention and policy* 5(2), 177–184.
- Uchtenhagen, A. (2006). *The Lisbon Agenda for Prisons. All on drugs and public health in prisons*, Lisbon.
- UKDPC (2008). *Reducing drug use, reducing reoffending. Are programmes for problem drug-using offenders in the UK supported by the evidence?* The UK Drug Policy Commission, London.
- UNAIDS, (1997). *Prisons and AIDS. UNAIDS technical update. UNAIDS Best Practice Collection*, United Nations Geneva.
- UNODC, WHO (2006). *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings A Framework for an Effective National Response Joint United Nations Programme on HIV/AIDS*. UNODC, World Health

Organization and the Joint United Nations Programme on HIV/AIDS
Vienna.

- UNODC, WHO Europe (2009). Women's health in prison. Correcting gender inequity in prison health.
- Van den Bergh, B.J., Gatherer, A., Moller, L.F. (2009). Women's health in prison: urgent need for improvement in gender equity and social justice. *Bull World Health Organ* 87, 406.
- Wakeman, S.E., Bowman, S.E., McKenzie, M., Jeronimo, A., Rich, J.D. (2009). Preventing death among the recently incarcerated: an argument for naloxone prescription before release. *Journal of Addictive Diseases* 28(2), 124–129.
- Walmsley, R. (2008a). World Prison Brief. <http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/>. accessed on 12.03.2009.
- Walmsley, R. (2008b). World Prison Brief Hungary. http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country_print.php?country=143. accessed on 19.06.2008.
- Walmsley, R. (2009). World Prison Brief Lithuania. http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country=151. accessed on 03.03.2010.
- Walmsley, R. (2010a). World Prison Brief Lithuania. http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country=151. accessed on 21.10.2010.
- Walmsley, R. (2010b). World Prison Brief Poland. http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/wpb_country.php?country=159. accessed on 09.03.2010.
- Welsh, W.N. (2007). A Multisite Evaluation of Prison-Based Therapeutic Community Drug Treatment. *Criminal Justice and Behavior*(34), 1481–1498.
- Whiteman, D., McCall, B., Falconer, A. (1998). Prevalence and determinants of hepatitis A virus exposure among prison entrants in Queensland, Australia: implications for public health control. *J Viral Hepat* 5(4), 277–283.
- WHO (1993). WHO guidelines on HIV infection and AIDS in prisons. WHO, WHO/GPA/DIR/93.3, Geneva.

- WHO, Regional Office for Europe, Health in Prisons Project, Pompidou Group of the Council of Europe (2001). Prisons, Drugs and Society – A Consensus Statement on Principles, Policies and Practices. London, Bern.
- WHO, UNAIDS (2001). Effectiveness of Condoms in Preventing Sexually Transmitted Infections Including HIV. www.who.int/HIV_AIDS/Condoms/effectiveness_of_condoms_in_prev.htm. accessed on August 15, 2001.
- WHO, UNAIDS, UNODC, (2004). Policy brief: reduction of HIV transmission in prisons, WHO, Geneva.
- WHO, UNAIDS, UNODC (2007a). Effectiveness of interventions to manage HIV in prisons – needle and syringe programmes and bleach and decontamination strategies. Evidence for Action Technical papers. World Health Organization, Geneva.
- WHO, UNAIDS, UNODC (2007b). Effectiveness of interventions to manage HIV in prisons – Opioid substitution therapies and other drug dependence treatment. Evidence for Action Technical Papers. World Health Organization, Geneva.
- WHO, UNAIDS, UNODC (2007c). Effectiveness of interventions to manage HIV in prisons – Provision of condoms and other measures to decrease sexual transmission. Evidence for action technical papers. World Health Organization, Geneva.
- WHO, UNODC, UNAIDS (2007d). Effectiveness of Intervention to address HIV in Prisons – HIV care, treatment and support: Evidence for Action Technical Paper. World Health Organization, Geneva.
- WHO, UNODC, UNAIDS (2009). Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. <http://www.who.int/hiv/pub/idu/targetsetting/en/index.html>. accessed on.
- WHO Europe, (2003). Moscow Declaration: Prison health as part of public health, WHO Europe, Copenhagen.
- WHO, (2005). Status paper on prisons, drugs and harm reduction, WHO Europe, Copenhagen.

- WHO Europe (2005). Prisons, Drugs and Harm Reduction. The vital role of harm reduction in prisons in reducing the harmful consequences of problematic drug use in society
- WHO Regional Office for Europe, Pompidou Group of the Council of Europe (2001). Prison, Drugs and Society. Bern.
- Winarso, I., Irawati, I., Eka, B., Nevendorff, L., Handoyo, P., Salim, H., Mesquita, F. (2006). Indonesian National Strategy for HIV/AIDS control in prisons: A public health approach for prisoners. *International Journal of Prisoner Health* 2(3), 243–249.
- Zurhold, H., Haasen, C. (2005). Women in prison: Responses of European prison systems to problematic drug users. *International Journal of Prisoner Health* 1(2–4), 127–141.
- Zurhold, H., Haasen, C., Stöver, H., (2005). Female Drug Users in European Prisons. A European study of prison policies, prison drug services and the women's perspectives, bis Verlag, Oldenburg.

Authors

Prof. Dr. Heino Stöver
University of Applied Sciences
Faculty „Health and Social Work“
Nibelungenplatz 1
D-60318 Frankfurt
hstoever@fb4.fh-frankfurt.de
www.isff.de

Katja Thane
University of Vechta
Institute for Social Work, Education and Sports Sciences
Driverstr. 22
D-49377 Vechta
katja.thane@uni-vechta.de