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**A Study of the Health Care Provision,
Existing Drug Services and Strategies Operating
in Prisons in Ten Countries
from Central and Eastern Europe**

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Summary

Overview

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) sets out guidelines for treating problematic drug and alcohol users, both of which are at greater risk of contracting HIV and other infectious diseases. Often, as a result of drugs misuse prior to incarceration, inmates are already carrying infectious diseases. However, the implementation of services to treat HIV/AIDS and drugs misuse both within prisons and in the community varies and is subject to a country's socio-economic circumstances, cultural attitudes towards HIV and drugs and existing resources. Prevention and treatment initiatives must overcome many cultural barriers relating to attitudes towards sex, especially homosexual activity, as well as providing enough resources to deal effectively with the problem. This may determine whether or not preventative measures (e.g., clean needles, condoms) are in place and to what extent they, along with sexual activity and tattooing, will impact on the risk levels of spreading infectious diseases. The prevalence of sexual activity in prisons needs to be acknowledged and addressed in order to prevent further infection within prisons and subsequently in the wider community.

The overall aims of the research were to:

- undertake a review of the services/initiatives operating in the area of health within two sample prisons in each of the countries;
- provide a report of the provision of services for drug-dependent prisoners in the ten countries;
- relate the provision of services to current Council of Europe and World Health Organisation guidelines and to the national strategies operating in each country;
- promote awareness of the initiatives operating within the sample prisons and facilitate the sharing of best practice on the national and international level.

The ten countries involved in the research were Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia. The field visits to all the countries apart from the Czech Republic, Poland and Slovenia were carried out by the author of this report. The research involved visiting at least two prisons and key non-governmental organisations (NGOs) working in the area of drug addiction in each of the ten countries.

Health care, drug use and communicable diseases in the community in the sample countries

It is useful to look at some of the factors in the wider community that have an effect on the prison administrations in each of the countries. These factors provide a context within which to place the problems that are facing the prison administrations in meeting the health care and drug services needs of their prison populations. The extent of drug use and communicable diseases in the wider communities of the ten countries will impact on the composition of their prison populations with potentially more drug users ending up in the prisons.

The countries in the sample are all experiencing changes and developments to their national health care systems since the political and social changes of 1989. The following trends in health care provision can be seen in most countries in the sample: a move away from central budget control to a centralised health insurance system, the gradual introduction of market principles and gradual recognition that the public system will be under-funded and, as a result, will be supported with private funding and insurance.

The ten countries involved in the research are all experiencing an increase in the extent of drug use. This is often concentrated in the capital city and, in some countries, most notably amongst young people.

The extent of HIV in the ten countries is variable and there is concern amongst authorities that this is spreading amongst injecting drug users (IDUs). Even in some of the countries where the rate is still low there is concern that the conditions are right for a high increase of HIV especially in marginalised communities.

Hepatitis is of concern across Central and Eastern Europe but the extent of the disease is not clearly monitored in all countries.

Key issues for the prison administrations of the ten countries

There are two principal problems facing the prison administrations of the ten countries, which in some instances reflect the situation in the wider community. First, there is an increasingly high number of problematic drug users in prisons. Some of these continue to use, and in some cases inject, drugs while in prison. Second, there is a high incidence of hepatitis and, in some of the countries, of HIV amongst prisoners. These problems are combined with wide-scale prison overcrowding and, in most cases, a desperate need for refurbishment. Internally, prisons have to deal with prisoner hierarchies that may lead to bullying and forced sex. Since the changes in 1989, most of the prison administrations are finding it difficult to provide work opportunities for prisoners.

Health care provision in prison

Prisoner confidentiality was not seen as a key issue in all the sample prisons and the degree to which it was maintained differed. As so many staff felt they had to know who was HIV-positive or hepatitis positive, there is clearly a need for further staff training about communicable diseases.

In some of the countries, 24-hour medical cover is provided in prisons. However, where this is not the case, this has led to medicines being distributed by security staff at weekends and during the evenings. Some security staff indicated that this could be problematic because they are not trained in this area. This practice, along with the difficulty in recruiting medical staff and budget deficiencies, raises doubts about how far the prison medical service has become equivalent to that provided in the wider community.

The majority of the countries have initiated refurbishment programmes to improve the living conditions of prisoners. This is a gradual process constrained by lack of finances in some of the countries.

Prevention and harm reduction

The political context in which prisons have to operate has led to variable provision of harm-reduction measures in the sample countries. The key areas where improvements are required in order to meet the needs of increasing numbers of problematic drug users in prison are the provision of harm-reduction information about drugs and communicable diseases for staff and prisoners and the provision of condoms, bleach, substitution treatment and needle exchange.

Drug treatment in prison

In countries where there was a developed National Drug Strategy there was more likely to be a prison administration Drug Strategy. Individual prisons in some of the countries where there was not a national prison drug strategy tended to focus on supply reduction rather than on demand reduction (with the emphasis on harm reduction and treatment programmes) for problematic drug users.

The availability of treatment programmes for problematic drug users depended on the availability of funding, trained staff and partnership with NGOs providing drug services in the community. Treatment for problematic drug users while available in some countries was not always available in all prisons and was rarely available for pre-trial prisoners. Short-term projects were offered in some prisons by NGOs. After the end of these projects, all activities that had been provided by the NGOs ceased. This indicates a need for the national prison administrations to make a commitment to provide assistance to enable the 'learning' from such projects to continue either by staff training or by providing financial support to NGOs providing such projects. Many of the activities initiated by NGO projects, for example prison staff training, would not be expensive for prison administrations to continue financing. In some countries, existing staff, after additional training, were offering drug therapy and this was found to be cost effective.

Prison staff

While multi-disciplinary working was recognised to be both important and vital in the delivery of services to prisoners, in the majority of the sample prisons there was limited training provided for staff to make this possible. Teamwork most often occurred between specialist staff and usually did not include medical and se-

curity staff. One problem that was cited was that security and specialist staff have different priorities and this could lead to difficulties in a multi-disciplinary approach. In some prisons where multi-disciplinary working was taking place, staff commented that this had led to better working relations between them. Multi-disciplinary working appears to work best in prisons where there is clear support for this approach from higher management.

In all the sample countries, staff training was highlighted as important especially for the continuing development of the prison system. The extent of the training available was variable with some prison systems mainly providing initial training and induction and others offering 'life long' training opportunities for staff throughout their career.

In the majority of the countries there was not a clear policy for staff welfare.

Conclusion and suggestions

There is, already in existence, a wide range of recommendations for the prison setting provided by international bodies covering prisoners' human rights, health care, harm reduction and drug treatment. It is, therefore, not considered appropriate to make recommendations that cover the ten countries that participated in the research. Rather, in order to find the best solutions for the particular problems in the sample prisons, it may be helpful for staff to discuss the key issues that have been identified in the report. Points will be made at the end of each section in the conclusion to provide a focus for this discussion. The suggestions are not aimed at specific countries or prisons and are meant to reflect the range of experiences that the countries involved in the research are experiencing and to enable the sharing of best practice.

The problems that confront the prison services of Central and Eastern Europe are shared with prison services across Europe. The sample countries are experiencing increasing drug use in the community and this is reflected in the prison population. This increasing drug use brings with it a higher prevalence of hepatitis and HIV and other drug related health risks.

This study has identified a range of good practice and new initiatives operating within the sample prisons in the provision of both health care and services for problematic drug users. These initiatives are provided by the prison administrations or NGOs or by the prison administrations in partnership with NGOs. Overall, however, there is little standardisation in approach within individual countries: much of the work undertaken has tended to be at the level of the individual initiative rather than a co-ordinated, national programme.

Equivalence of care

Human rights principles require that prisoners should receive health care at least equivalent to that available for the outside population. Staff shortages in some prisons make it difficult to ensure equivalence of health care. In some of the sample countries, the budget for health care was not considered to be adequate to meet all the health needs of the prison population. It is suggested that:

- the particular health needs of women and juveniles should be addressed to ensure equivalence;
- health care budgets should be kept under review to meet the needs of the prison population by providing adequate health care services and medicines, as far as possible free of charge;
- the practice of leaving security staff to distribute medicines should be reconsidered.

Confidentiality

The prison administrations are at different stages in developing a clear understanding of the importance of prisoner confidentiality. Confidentiality is difficult to ensure in the prison environment and the sample prisons achieved prisoner confidentiality to varying degrees. While some prisons have instigated policies to increase confidentiality, others still need to make further improvements to meet the WHO Guidelines (31, 32). It is suggested that:

- strategies should be employed to ensure prisoners' confidentiality;
- staff training programmes should be implemented to address the importance of maintaining prisoners' confidentiality.

Bullying

Other aspects of prisoner culture are being addressed with varying success by the prison services, most notably bullying. In all of the countries, bullying was not tolerated. However, there was not always a clear anti-bullying strategy in place.

Bullying and forced sex can also be linked to the existence of the prisoner hierarchy and here the response of prison services has been varied. This is an area that demands attention especially in juvenile prisons where prisoners as young as sixteen are potentially at risk. It is suggested that:

- a 'whole prison' approach should be developed where all staff and prisoners show a commitment to reduce and prevent bullying and are aware of the prison anti-bullying strategies;
- measures should be taken to reduce the power of the prisoner hierarchy.

Self-harm

Prisons contain people who are particularly vulnerable to self-harm, and the environment itself can contribute to people self-harming. Although the majority of the sample countries reported that the incidence of self-harm had reduced since the changes in 1989, recording practices were not always clear. Research is needed to provide a more comprehensive picture of the extent of self-harm in prisons in the region. The study identified that the majority of staff working in the sample prisons considered self-harm as being manipulative. A combination of staff shortages, lack of staff continuity, inadequate training and lack of information sharing can all impair the ability of staff to identify and care for prisoners at risk of self-harm. It is suggested that:

- training should be provided that challenges negative attitudes to prisoners who self-harm;
- there is a need for a holistic approach where all staff and prisoners show a commitment to reduce and prevent self-harm.

Harm reduction

HIV, hepatitis B and C are major challenges facing prisons in Europe. Whereas, HIV testing is available in the majority of prison systems, testing for hepatitis is very rarely available to injecting drug users at entry to prison resulting in a lack of prevention messages and vaccination programmes. As prison administrations receive more prisoners with a history of problematic drug use, the prevalence of hepatitis C and HIV may become much higher. If voluntary testing for HIV and HCV becomes more accessible for prisoners this will also raise the need for more pre- and post-test counselling for prisoners. Prison systems have a moral responsibility to prevent the spread of infectious diseases among prisoners, to prison staff and the public and to care for prisoners living with HIV and other infections. The emergence of HIV anti-retroviral treatments and combination therapies have been successful in improving the health of people living with HIV and prisons present an opportunity for prisoners (particularly injecting drug users) to have a (voluntary) HIV test and to access treatment if required. It is suggested that:

- HIV testing protocols including pre- and post-test counselling should be implemented and adhered to in all prisons;
- implementation of strategies that provide prevention messages and vaccination programmes for hepatitis should be considered;
- treatment and prevention of communicable diseases (HIV, TB, STDs, hepatitis B and C) should be provided.

Although most prison administrations are looking at the issue of problematic drug use in prisons seriously, harm reduction is still not receiving sufficient attention in all of the countries visited because of competing priorities. As prison policy is often implemented differently in different prisons, prevention measures such as condoms, bleach and information provision are sporadic and patchy. Provision of such prevention materials is often dependent on short-term programmes provided by NGOs and international bodies and ceases at the end of the project. However, the development of prevention measures should be seen as an opportunity to meet the health and treatment needs of problematic drug users (a group often difficult to reach in the community) that are increasingly represented in prison in all the countries. It is suggested that:

- a harm reduction strategy should be developed to ensure the provision of information and services to meet the needs of prisoners;
- harm reduction materials should be available for all prisoners both sentenced and pre-trial. There should be clear procedures, measurable standards, monitoring and evaluation of the provision.

The fundamental problem facing attempts to address problematic drug use across the sample prisons was the lack of any formalised prison drug strategy in any of the ten countries. Even in those countries where a more formal approach was taken, it was usually developed from the National Drug Strategy and its main focus was often on supply reduction rather than demand reduction. Most experts and policy makers agree that in order to meet the needs of problematic drug users ‘it must not be either supply reduction or demand reduction but that both strategies must get simultaneously equal attention and funding’ (Goose, 1996).

- each prison needs to adapt the national prison administration’s drug strategy and develop its own specific drug strategy to meet the particular circumstances in the prison;
- the particular needs of women and juveniles must be addressed;
- in prisons where there are both pre-trial and sentenced prisoners, the drug strategy should meet the requirements of both groups .

Condoms form a crucial component of a harm-reduction strategy, even though they will not totally stop the risk of transmission of Sexually Transmitted Infections (STIs). They are provided for intimate visits in some countries but for general use only in Estonian and Slovenian prisons. In most of the countries, they can be bought in the prison shop. However, in reality prisoners are deterred from buying condoms openly because of the taboo surrounding men having sex with men and because they simply do not have enough money. In order to introduce condoms into prisons for general use, there is a need first for training to change the attitudes of both staff and prisoners. It is suggested that:

- the possibility of providing condoms for general use within prisons, and educational programmes to change attitudes towards such initiatives, should be explored;
- courses that address prevention and harm reduction in an interactive way (i.e., courses on the safer use of drugs and on safe sex) should be supported and provided on a regular basis for prisoners and staff.

A vital component in any harm reduction strategy for problematic drug use is syringe exchange programmes (SEPs). However, although the prison services of some of the countries indicated that they would consider the possibility of introducing this strategy in the future, they reported that currently their priority was on supply reduction of drugs rather than on prevention. Strategies such as SEPs, where they already exist, demonstrate the impact of acknowledging prisoners’ rights to treatment whilst ensuring that while they continue to use drugs, they are not spreading infectious diseases. SEPs have been shown to be feasible in terms of their implementation, efficient and effective in that they do not increase injecting drug use and are not misused by prisoners. In conjunction with other measures, they form an important part of reducing the harm caused by problematic drug use; however, as with other measures, to be delivered properly they need to be accepted by prison authorities and given the appropriate resources and management (Stöver & Nelles, 2003). It is suggested that:

- the provision of needle exchange in prisons should be kept under review.

- discussion about whether to offer substitution treatment in prison should continue. It may be helpful to include the NGOs with experience in this area in the discussions;
- a programme of staff training should be established to ensure the future cooperation of prison staff in such programmes.

Provision of harm-reduction information to prisoners was reliant in some cases on non-interactive methods, such as written information or a video supplied by the prison department. This also raises the issue as to how well informed prisoners, who are not drug users, are about harm-reduction information. The problem of providing effective harm-reduction information is more acute for pre-trial prisoners who may be in prison for short periods, thus making programmes hard to provide, or who are difficult to access due to restrictions imposed by the court.

- Regular courses that use interactive methods should be provided for prisoners to provide them with safer drug use/safer sex information, for example by using peer educators.

The general feeling amongst staff working in the sample prisons was that there was a need for more staff training in the field of drugs and communicable diseases as this was important in order to meet the needs of an ever-increasing number of drug-dependent prisoners entering the prisons. It is suggested that:

- the precise training needs of the prison staff should be evaluated to reflect the changing nature of the prison population;
- courses that address drug issues, prevention and harm reduction should continue to be supported and provided on a regular basis for staff in order to decrease negative feelings towards drug users.

Drug services and treatment

A key step in the provision of drug services for prisoners is an official recognition that drugs are often available in prison and that some prisoners will engage in high risk behaviour (for example, injecting drug use). The availability of drugs in prison was officially acknowledged in most of the sample countries. The extent of drug use that occurred was variable between prisons within a country. While an emphasis on reducing the supply of drugs entering the prison goes some way to reducing the incidence of drug use in prison, it is also necessary to provide more activities for prisoners in order to reduce the boredom of prison life and to offer a range of drug treatment options. It is suggested that:

- where possible, occupational activities and training for prisoners should be provided.

The research suggests that the lack of a drug strategy in a prison administration impacts on the development of suitable drug treatments for prisoners. In some of the countries the lack of drug treatment was raised as a problem both by prisoners and by some staff. Amongst the ten countries, a range of treatment options were available but were not available in all prisons within a country or in all of the

countries. In some of the countries the courts ordered compulsory drug treatment as part of the prisoners' sentence. Research is necessary to establish how far there is a difference between the outcomes of voluntary and compulsory drug treatment programmes.

The research has shown that negative attitudes towards drug treatment are widespread amongst prisoners within the prisons of Central and Eastern Europe and that this is a major barrier to change. It is not sufficient just to provide drug treatment programmes because there is a culture among the prisoners not to seek help with drug addiction and this also needs to be addressed. Peer education is one way of encouraging more prisoners to attend drug programmes and this was seen to have a positive effect in persuading prisoners to seek help with drug-dependency problems. In addition, some staff and prisoners from some sample prisons felt that a number of prison staff held very negative attitudes towards drug-using prisoners. The training provided for staff to improve their expertise on drug use and communicable diseases is crucial to ensure the continuing development of services for drug users in prison and to challenge negative stereotypes of problematic drug users. It is suggested that:

- methods to identify problematic drug users should not discriminate against them and cause them to be reluctant to seek help in addressing their drug use;
- evaluation should be built into the implementation of all new initiatives for drug treatment and services;
- prison-based treatment programmes (for example Drug Free Units) should have clear national standards and should, where appropriate, establish partnerships with drug services in the community (NGOs and community services).

Consideration of the availability of treatments demonstrates the divergence between what is officially available and what the prisoners, in effect, have access to. Substitution treatment was available in Poland and in Slovenia but not in the other eight sample countries. Detoxification was available in most of the countries either at a prison hospital or provided by an external organisation. However, some prisoners have pointed out that they had not received sufficient help during detoxification and in some cases had been provided with no services at all. It is suggested that:

- a national strategy should be prepared for the implementation of substitution programmes, in order to overcome problems with the transfer of prisoners between prisons and from prison to the community.

NGOs

A key role has been played by NGOs in providing services and support for prisoners. The NGOs offering drug services that were visited during the course of the research had a range of involvement in all but two of the prison systems. They were actively involved in a range of activities, such as reintegration of prisoners, through care, counselling and support, therapy and rehabilitation, HIV prevention, provision of harm-reduction information, harm reduction, peer

programmes and training staff and prisoners. Yet specialist staff, from the NGOs visited, raised a number of problems that they encountered in their work with the prison systems. It is suggested that:

- to address the issue of sustainability in short-term funded programmes, the learning from the NGO programmes operating in particular prisons should be embedded in the prison structure to enable continuing provision for prisoners when the programme ends;
- to ensure effective collaboration between the national prison administration and NGOs providing services, there needs to be commitment from individual prison managements as well as from the national prison administration.

Through care

In order for partnership between NGOs and prisons to be productive it is important that the NGOs are well organised with professional staff and that there is good collaboration with the national prison service (this could be in the form of a written contract) as well as commitment from individual prison managements. NGOs have an important and valuable role to play in the provision of drug services for prisoners and in providing a bridge between the prison and the community.

The provision of through care is a developing area in the sample countries and was identified as a problem in all of them. Most of the prisons in the research identified NGOs as having a key role to play in providing through care. In all of the sample prisons there were representatives from religious groups who were present in the prisons, some of whom offered a degree of support to prisoners after release from prison. In most of the prisons, there were also NGOs offering support in specific areas to prisoners at the time of release. But there were not always services available to help prisoners at the time of release in the community. Staff in some prisons felt that the development of the probation service in their communities would eventually help to improve through care for prisoners.

Multi-disciplinary working

Finally, it is clear from this study that multi-disciplinary working is essential to the success of initiatives across central and eastern European prisons and this appears to have been accepted by many staff. Nevertheless, the research has shown that multi-disciplinary working is not happening in all the sample prisons. Staff shortages and a high prison population are suggested as reasons why multi-disciplinary working, although desirable, was not always possible. Multi-disciplinary working tended to be most effective in prisons where top management took the lead in instigating this way of working. It is suggested that:

- training should be provided to encourage multi-disciplinary working.

Chapter 1

Introduction

The Central and Eastern European Network of Drug Services in Prison (CEENDSP) with the scientific support of the European Institute for Crime Prevention and Control, affiliated with the United Nations (HEUNI) commissioned a research project on health care and the provision of services and treatment for problematic drug users in prison. The research was co-funded by the European Commission PHARE Programme to be carried out in ten central and eastern European countries, all of which were due to join the EU. Eight of the ten subsequently became members on May 1st, 2004 and Bulgaria and Romania are expected to do so in 2007. The ten countries involved in the research were Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia. The field visits to all the countries apart from the Czech Republic, Poland and Slovenia¹ were carried out by the author of this report.

Access to the prison administrations of the ten countries was arranged under the auspices of HEUNI. There were no problems in any of the sample countries in gaining access to visit prisons and interview staff and prisoners.

A country co-ordinator was appointed in each sample country who played a key role in the process of this research. Each country co-ordinator provided background information about the prison system, health system and drug policy and provision in their country using a proforma (see Appendix 1). The country co-ordinators also facilitated the visit of the researcher to their country and provided feedback on the individual country report² that was provided for each of the sample countries. The country co-ordinators also helped in arranging the visits to the sample prisons, identifying key NGOs and identifying an independent translator. Independent translators were used to ensure confidentiality both for prison staff and for prisoners during the interviews.

Each of the sample countries will be discussed under the key themes that arose from the research. The aim is not to compare the sample countries but rather to discuss the prison administrations' provision of health care and responses to problematic drug users and the role of NGOs in the provision of drug services in prison in the context of the problems faced by the sample countries.

1 The data for the field report for Poland was collected by Dr. Heino Stover and for the Czech Republic and Slovenia by Laetitia Hennebel.

2 A country report was written for each of the participating countries and these will be available on CEENDPS Website in English and the language of the country that the report refers to.

Methodology

The overall aims of the research were to:

- undertake a review of the services/initiatives operating in the area of health within two sample prisons in each of the countries;
- provide a report of the provision of services for drug-dependent prisoners in the ten countries;
- relate the provision of services to current Council of Europe and World Health Organisation guidelines and to the national strategies operating in each country;
- promote awareness of the initiatives operating within the sample prisons and facilitate the sharing of best practice on the national and international level.

The research involved visiting at least two prisons and key NGOs (working in the area of drug addiction) in each of the ten countries. The names and types of prison in the ten countries can be seen in Figure 1 and the NGOs and other governmental organisations interviewed in Figure 2.

Figure 1. Prisons in the sample

Country	Prisons Visited	Type	Category of Prisoner	Prison population (date)
Bulgaria	Lovech	Adult Male	Sentenced/pre-trial	1480 (7/03)
	Varna	Adult Male	Sentenced/pre-trial	889 (7/03)
Czech Republic	Opava	Adult Male Women + Juveniles	Pre-trial/Sentenced	-
	Příbram	Adult Male	Sentenced	
Estonia	Viljandi	Juvenile Male	Sentenced	65 (6/03)
	Tartu	Adult Male/Women	Sentenced men/ pre-trial women	840 (5/03)
Hungary	Budapest	Adult Male/Female	Sentenced/pre-trial	-
	Baracska	Adult Male	Sentenced	852 (11/03)
Latvia	Parlielupes	Adult Male	Sentenced	627 (7/03)
	Ilguciema	Adult + Juvenile Female	Sentenced/pre-trial	473 (7/03)
Lithuania	Kaunas	Male Juvenile	Sentenced/pre-trial	166 (10/03)
	Alytus	Adult Male	Sentenced	1399 (10/03)
Poland	Sluzewiec	Adult Male	Pre-trial/Sentenced	-
	Montelupich	Adult Male	Pre-trial/Sentenced	
Romania	Târgsor	Female	Sentenced/pre-trial	600 (1/04)
	Rahova	Male, Juvenile and Women's section	Sentenced/pre-trial women	2500 (1/04)
Slovakia	Trenčín Prison Hospital	Male/Female	Pre-trial/Sentenced	156 beds
	Sučany–Martin	Male Juvenile + Adult male	Pre-trial/Sentenced	248 (01/04)
	Bratislava	Adult Male	Pre-trial	650 (01/04)
Slovenia	Ilava	Adult Male	Sentenced High Security	493 (01/03)
	Ljubljana	Adult Male	Pre-trial/Sentenced	223 (9/03)
	Dob	Adult Male	Sentenced + semi open	364 (9/03)

Figure 2. NGOs and Governmental Organisations in the sample

Country	NGOs and Governmental Organisations visited
Bulgaria	Association of Varna NGOs Net31Rem Varna regional Social Work Department
Czech Republic	Sdružení Podané Ruce Brno, SANANIM LAXUS
Estonia	Estonian Association Anti AIDS AIDS Information and Support Centre Estonian AIDS Prevention Centre CONVICTUS.
Hungary	Ráckeresztúr Drug Therapy Home Blue Point
Latvia	DiaLogs
Lithuania	The Prisoners' Aid Association CARITAS project for ex-prisoners.
Poland	Monar Poland Monar Kraków Slawek Foundation
Romania	ARAS ALIAT
Slovakia	PRIMA Odyssey Centre for Treatment of Drug Dependencies The National Reference Centre (HIV)
Slovenia	Skala Youth Street Education, Areal Stigma

The research involved interviews with key specialists working in the sample prisons and a focus group with a sample of prisoners in each prison. Interviews were also carried out with key officials from the national prison administration in each country and other governmental organisations. The sample prisons were chosen via negotiation with both the country co-ordinators and the national prison administrations. Criteria in selecting the sample prisons were that, where possible, the prisons selected should have drug-treatment facilities, and include at least two of the following categories of prisoners: sentenced, pre-trial, young offenders and women. This was not always possible and the majority of prisons visited were for sentenced and pre-trial adult men. Prisoner focus groups were only possible with sentenced prisoners due to the difficulty in getting permission from the prosecution services to interview pre-trial prisoners. Negotiating access to the prisoners in the sample was not a one-off event but continuous with access

being negotiated separately for every prison. The nature of the research subject required that the researcher and translator were left alone with prisoners without the presence of security staff. However, this was difficult to negotiate in some of the prisons in the sample despite agreement having been made in advance with the national prison administration.

Linguistic difficulties are a major inhibitor of comparative research. Unless the researcher is fluent in the language and cultural concepts of the countries being compared there is a danger of misinterpreting data. Without good linguistic skills it is possible to miss the subtleties of 'intonation, nuances of speech, or most problematic of all, that which is left unsaid' (Zedner, 1995, p. 12). In addition, one could argue that linguistic skill alone is not sufficient if the researcher does not understand the subculture and the jargon or argot used (Polisky, 1971). It was necessary to use translators during the visits to each of the sample countries. The translators used in the research were usually university graduates, not usually from the field of criminology and in one country a professional translator was used. Prior to the interviews the aims and objectives of the research and the methods used were discussed with the translator. It was also important to explore the nature of empathetic interviews with translators.

The translators' lack of experience in the area of prisons was, on the whole, an advantage during the research as they were able to explore the meanings of terms used in detail during the interviews adding to the clarity of the data collected and reducing the possibility of taken-for-granted culturally-specific understandings. The comparative researcher also needs to be wary of organisations that appear similar on the surface because they bear a similar name but which, in reality, operate very differently in different settings. Official descriptions can be problematic as they may hide substantial differences in their actual form, culture and purpose. There are many 'dangers' that can confront comparative research. For example, an 'outsider' may ask inappropriate questions about the society that they are comparing because they do not understand the culture of that society. Equally, 'insider' researchers may also fail to grasp what are perhaps key features about that society as seen from the outside. On the other hand, an 'outsider' may bring a different perspective to comparative research because of his/her geographical and cultural distance. This also allows the researcher to ask 'naive' questions that challenge presuppositions. Similarly, 'as a "nobody" one may be allowed access to information or be made party to disclosures which prudence might withhold from a fellow national' (Zedner, 1995, p. 18).

To provide an in-depth analysis of the processes involved in the development of prisons' drugs policy in the ten sample countries, a qualitative case study design was chosen as the most appropriate methodology. In a study such as this, positivistic research models are of limited use, whereas qualitative approaches offer distinct advantages (Pollitt *et al.*, 1992; Koestler, 1993). For example, while quantitative measures can give rise to important descriptive data, they do not provide information or access to meanings and choices in the development and implementation of policy. There is also:

the danger with quantitative studies, which stress inputs, outputs, indicators and measures of performance, of forcing complex processes into preconceived categories and assuming that the policy process is linear. Qualitative methods can be used to delve into parts of the policy process, which quantitative methods cannot reach. They have the potential to explore innovation, originality, complexity, interactions, conflicts and contradictions. Moreover, such approaches can focus on broad questions, rather than narrow ones. In terms of ethics, there is a commitment to ground interpretations in the perceptions of those studied (Pollitt *et al.*, 1992), thus producing more authentic accounts. Even if the researcher is critical of the viewpoint expressed by those studied, this commitment is important in order to increase understanding. (Duke, 2002:4)

The importance of understanding and recognising the viewpoint and position of the key stakeholders being studied (prison administrations, prisoners, NGOs, government organisations) is stressed in the research and the qualitative approach and its associated techniques made this possible.

The research consisted of an interview checklist containing indicative questions relating to specific areas of prison policy and practice. This was used with prison staff, staff from the national prison administrations and prisoner focus groups (see Appendix). A second checklist was used for the interviews with NGO staff. The nature of this research precludes generalisations across the prison systems of the sample prisons but focuses on the prisons visited in each country.

Ethics

Doing research in prison is particularly difficult when the policies under discussion involve behaviour that may be subject to disciplinary punishment such as illicit drug taking and sex between men in prison. In some cases, there is neither official recognition by staff of these behaviours occurring nor any acknowledgement of there being any other significant problems within prisons.

Dealing with sensitive subjects like drug use in prison and HIV/AIDS and related sexual behaviour can make prisons seem, on occasions, inhospitable environments. Thus, it is important for the research to be underpinned by clear ethical guidelines for the protection of both the research subjects and the researcher. This research followed the ethical guidelines provided by the British Sociological Association. Prison staff were informed at the beginning of the interview that what they said would be treated confidentially and that they would not be named in the report. Prisoners at the beginning of the focus group were asked if they were happy to participate in the discussion and told that they were free to leave at any point during the discussion and that everything said during the group would be kept confidential.

Description of the prisons and NGOs involved in the research

In each country researchers visited two prisons and where possible, at least one NGO that either had links with the prison service or offered drug services in the community.

In Bulgaria the researcher visited Lovech and Varna prisons. Lovech is quite typical of Bulgarian prisons, not only in consisting of several different types of institution but also in being spread over three sites and consisting of several buildings, all under the direction of a single prison director. During the visit, the main prison for recidivists (based in Lovech itself) and the associated transitional prison (in Troyan) were visited. The focus group with prisoners took place at the transitional prison (for non-recidivists) in Troyan. The other prison under the direction of the Director of Lovech prison is an open prison at Turnovo.

The prison in Lovech has a total staff of 330 and a good range of specialists. The prisoners were all over 18 years of age. Juvenile prisoners are in special institutions for 14–18 years olds elsewhere in the region. The population of the prison at the time of the visit was 1,480 spread across the three institutions (July 2003). In the main prison there are only sentenced prisoners.

If the prisoners behave satisfactorily in Troyan prison they have a less strict regime and are rewarded. A prisoner's security category may change after consideration by a group of specialists. The prisoners are evaluated every three months if they have been moved from a regime for bad behaviour.

There are many drug-dependent prisoners at Lovech prison who come from Varna. Varna is one of the gates for drug trafficking from the sea. Most drug-dependent prisoners are from Varna and they are considered to be difficult to work with as they are young – between 20 and 30 years old. These prisoners have used a wide range of drugs and they make up 80 per cent of the prison population. One of the only two prison hospitals is situated in Lovech prison and prisoners with drug or alcohol dependence are sent here for treatment.

The official capacity of the main prison in Varna is 350. Currently there are 600 prisoners so there is about 70 per cent overcrowding. This prison has a number of other smaller prisons under its general management: a transitional prison, an open prison (for first time offenders) and a prison farm. There are 889 prisoners in total under the management of the director of Varna prison.

The Bulgarian Department for Punishment Execution is committed to building links with outside agencies in a variety of areas. Some NGOs are already working in some prisons on the issue of drugs use. During the visit to Bulgaria, representatives from two NGOs and Professor George Popov, the president of the Association of Bulgarian Hospitals, were interviewed. In Varna there are many projects working with drug users in the community and the institutions represented by the National Council of Drugs (a division of the Regional Government)³ are ready to start working with the prisons. The Department for Pun-

3 The idea of the council is to combine the efforts of the NGOs with the state institutions. Varna is very different from other towns because the local and regional governments are working closely together and with the NGOs. This is not happening in other towns. In addition this collaboration is well established and not based on party politics.

ishment Execution is considered to be concerned about drugs, open minded and ready to try different initiatives involving NGOs. In some cases the prisons themselves are more open than the Department for Punishment Execution in developing partnerships with NGOs. For example, the Director of Varna prison is a member of the Municipality's Commission of NGOs working with drugs⁴. There are, however, only two or three NGOs in the association who are working with prisoners. The NGOs in the association are concerned primarily with the prevention of drug use amongst students and their main work is with teachers, parents, school nurses and the pupils.

In 1997 the local government in Varna created a separate department of social work that organised the first project with women prisoners in the region of Varna. In the Bulgarian prison system working with prisoners and ex-prisoners and their families is considered to be difficult. For example, in the first project of its kind in the Varna region when staff from the Social Work department were working in the prison with groups of women prisoners, the Director of the prison wanted guards to be in the room during the discussion in order to find out what the women said about such issues as how drugs get into prison. Subsequently, better relations were established where the need for the discussions between the women and the social workers to be confidential was understood by the prison management. This project finished in 2002.

NGO staff who were interviewed believe that NGOs are now stronger than they were but that there are many non-specialists who are not acting appropriately. The establishment of the *Association of Varna of NGOs working with drugs* is viewed as one way of regulating their behaviour.

In the Czech Republic Opava and Příbram prisons were visited. Opava prison has female and male prisoners, juveniles and drug-dependent offenders. Juveniles and male prisoners (in the lowest security category) are in one building. In another building women prisoners are held including drug-dependent offenders and high security prisoners. The prison has a capacity of 399 prisoners. At the time of the visit there were 368 prisoners (Prison Director, Opava prison 2003); 38 male juvenile prisoners (aged 15–18 years but some over 18 years)⁵ were kept in a separate building.

At the time of the visit (September 2003) the population of Příbram prison was 600. In 1992 the prison population was 1,000. The decrease is due to changes in penal policy and the availability of alternative punishments. The prison has three wings with approximately 200 prisoners in each wing. One of the wings is currently being refurbished. On each floor there is a TV/cultural room (non-smoking), a bathroom (with four showers and five washbasins per floor). Smokers are put together in the same room and are allowed to smoke in their rooms. The prison also has a specialist drug treatment department and drug free zone.

4 The association aims to unite all NGOs working in the field of drugs. This association works closely with the National Council of Drugs.

5 There are also some prisoners who are 21 years old in the juvenile building, due to the decision of the Court. Sometimes juveniles receive long sentences and the Court decides that juveniles must stay in the prison and in that section for longer.

Three NGOs were visited in the Czech Republic. Sdružení Podané Ruce in Brno was the first NGO to work in a prison and began in 1997. It was also the first NGO to have contracts with individual prisons that allowed them to move about the prison unaccompanied by a guard. Sdružení Podané Ruce works with five different prisons.

SANANIM, based in Prague, has clients all over the country and contact is via letter if the client is located far away. SANANIM provides a drop-in centre that focuses on harm reduction and helps clients liaise with GPs, psychologists, psychotherapist, psychiatrists, etc. In 1998 the programme with prisons started. SANANIM works in two prisons in Prague. Laxus, also based in Prague, works on three programmes: contact/ K centres, fieldwork and outreach services. Laxus works with one pre-trial prison (that also has a section for sentenced prisoners) with the most minor offences. The NGO also visits prisons that are located out of this geographical area and works with the local contact centre.

In Estonia the prisons visited were at Viljandi and Tartu. Viljandi prison is a closed prison with 65 prisoners; the official capacity is 100. Some staff from the prison expressed a concern that if the number of prisoners increased this would inhibit the rehabilitation work that they were currently able to do with the young prisoners. Rehabilitation work is further complicated by the fact that more than half of the prison's population is non-Estonian (54 per cent Russians and 3 per cent other). In addition, almost half (46 per cent) of the prisoners are thought to have been involved with drug use.

The age range of juvenile prisoners is from 14 to 21 years of age. When the prisoners reach 21 they go to an adult prison to complete their sentences, although they can go at the age of 18 years. Some of the older prisoners in Viljandi prison would like to go now, as this is a no smoking prison where neither staff nor prisoners can smoke in the prison. Because of its unpopularity, this no smoking policy was introduced gradually by the prison authorities but it remains unpopular with the prisoners.

Tartu is a modern prison for pre-trial and sentenced men and a small number of pre-trial women and had been open for six months. The official capacity of this prison is 908 (350 sentenced prisoners and 558 pre-trial prisoners). At the time of the visit there were 840 prisoners (6 May 2003). From information received from prisoners at reception to the prison, it was estimated that 70 per cent had used drugs previously.

The Estonian prison administration is committed to building links with outside agencies in a variety of areas. Some NGOs are already working with the prison department in the areas of HIV, drugs and staff training. During the visit to Estonia, three NGOs who work with the prison department were interviewed.

The Estonian Association Anti-AIDS NGO applies for money using their NGO status to finance projects in the prisons. One key problem identified amongst prisoners from Ida-Viru County (the cities of Narva, Kohtla-Järve, Sillamäe) was hepatitis B and C. As a result of a Danish Project carried out in August 2002, 500 prisoners have had hepatitis vaccination at Tallinn prison. The prisoners were given three vaccinations during a one month trial. However, this was a one-off event in the prison. This NGO has also been involved in HIV training of staff in prison and some peer education amongst prisoners.

The Estonian AIDS Centre ran a project in 2002 where they provided lectures for prison directors, social workers and medical staff and prisoners (particularly women prisoners in Harku prison). They trained 150 women prisoners in HIV prevention, safe sex and infectious diseases. They have worked in all Estonian prisons lecturing about HIV, hepatitis and safer sex.

The CONVICTUS NGO supports HIV-positive people and those with a drug addiction; they offer self-help, prevention and rehabilitation centres. The representative from CONVICTUS said that at the administrative level prison staff have been helpful and no restrictions have been put on them. The important thing for staff at CONVICTUS is that their work continues as the prisoners now know about the projects and want to know more.

In Hungary the Forensic Observation and Psychiatric Institute and Baracska National Prison were visited. The Forensic Observation and Psychiatric Institute deals with prisoners who require withdrawal and has a programme for drug-dependent prisoners. The programme for problematic drug users started in 1999 in the Institute (see section on drug treatment).

Baracska National prison has a minimum and medium security regime (the regime is imposed by the court). The prison originally consisted of a number of small houses in which prisoners lived. In the mid 1970s, new buildings were constructed with rooms for six to eight people, with a toilet and community room on a corridor. Prisoners come from all over Hungary after they have been sentenced. The prison caters for adult male prisoners in three groups:

1. People sentenced for traffic violations and other similar crimes and who are unable to pay fines.
2. A healing and education group for drug and alcohol users and mentally ill prisoners.
3. A special unit for chronically ill or disabled prisoners.

The NGOs visited were the Ráckeresztúr Drug Therapy Home and Blue Point. The drug therapy home is owned by the Reformed Church. The community provides places for up to twelve men. The clients mostly come from Budapest and self-refer from their first point of contact with the church in Budapest. The Ráckeresztúr Drug Therapy Home does not have very strong links with the local prison. The director of the drug therapy home has been involved with counselling on the drug prevention unit. Blue Point is a consultancy centre and drug clinic that offers therapy to stop using drugs, harm reduction, a club and they also provide some outreach services to drug users. They also provide a mobile needle exchange programme in five areas of Budapest. Blue Point also provides the drug programmes as an alternative to prison for drug users who are sentenced for having drugs and who are using the same programme as provided by the Forensic Observation and Psychiatric Institute for prisoners.

In Latvia the first prison visited was Ilguciema prison for women and juveniles in Riga and the second was Pārlielupes male closed prison in Jelgava. Ilguciema prison is a semi-closed prison that was housing 473 prisoners, although the official capacity is 389. Pārlielupes prison had 627 prisoners at the time of the visit (July 2003) although the official capacity is 530.

At the time of the visit Ilguciema prison had seven juvenile prisoners (younger than eighteen years old). Ilguciema prison also has a childcare unit for fourteen women and their babies. The unit is modern, bright and clean and one part is being refurbished as this unit is seen as a priority for renovation. The unit for juvenile prisoners has also recently been renovated. The prison director considered the buildings of the rest of the prison were also in need of renovation as they were very old.

Only one NGO was visited which had links with prisons. DiaLogs is an NGO for those people who are HIV-positive. There is also a needle exchange run from the same office provided by the AIDS Centre. Staff from the NGO considered there to be good co-operation with the prison authorities.

In Lithuania Kaunas Juvenile pre-trial prison⁶ and Correction House and Alytus Correction House were visited.

Kaunas Juvenile prison is unique in Lithuania, catering for sentenced and pre-trial male juveniles. The official capacity of this prison is 133 prisoners in the pre-trial prison and 222 in the Correction House (for sentenced prisoners). Currently there are 74 pre-trial prisoners and 92 sentenced prisoners (Director, Kaunas Juvenile pre-trial prison and Correction House, October 2003). The reduced number of prisoners is due to recent changes in the penal code. The juvenile prison caters for 14 to 18 year olds but if they behave well they are able to complete their sentence here until the age of 21. At the time of the visit there were eight prisoners over 18 years of age.

Alytus Correction House is mainly for sentenced men. Its official capacity is 1570 prisoners and at the time of the visit there were 1399 prisoners (7 October 2003). The prison has a young staff and the director changed recently due to an outbreak of HIV in the prison that caused some restructuring of the prison management. The prison has three regimes and also a closed zone (disciplinary section) for those prisoners who break the rules of the Correction House and can spend up to fifteen days on this section or in some cases one to six months. Prisoners are divided into sections of 200 prisoners and within each section there are 12 to 16 prisoners per room. Prisoners are free to move about their section and there is an enclosed area around each section where prisoners are free to walk.

The Correctional Affairs Department was open to working with NGOs but currently there are not many NGOs that want to work with the prisons. The director of Alytus Correction House was also open to all who want to work with drug users in the prison. Currently there are a few charities, such as CARITAS working with prisoners. All of the charities that come into the prison deal with social issues but not specifically drugs.

The Prisoners' Aid Association was visited, an NGO operating in Vilnius, which deals, at their day centre, with prisoners and other people who are at risk of social exclusion. The centre caters for both men and women. Prisoners have a right, after serving one third of their sentence (depending on the crime committed), to spend the rest of their sentence at this day centre. A prisoner makes an application to the prison director to attend the day centre and a meeting is then ar-

6 The research took place mainly in the pre-trial prison. Sentenced prisoners are in a different building with different regimes but under the management of the same director.

ranged with the centre and the prison to discuss the prisoner's suitability to attend the day centre.

In Kaunas there is an NGO that works in co-operation with CARITAS to help ex-prisoners to reintegrate into society. The organisation has been registered for the last ten years. The project is funded by SOROS and from 2004 the NGO will get some money from Kaunas municipality. They currently have twelve men on the project but with additional funding they could take a further twelve.

The two prisons visited in Poland were Sluzewiec prison in Warsaw that has a capacity of 858 for sentenced and pre-trial male prisoners and Montelupich prison in Kraków that currently holds 815 prisoners, of which 329 are sentenced and 486 prisoners are pre-trial.

The two NGOs visited were Monar and the Slawek Foundation. Both work in the sample prisons. Monar is a non-governmental, non-political association, which was officially registered in 1981 and operates all over Poland. An agreement between Monar and the Central Board of the Prison Department has been signed as of the 4th of December 2003. This will allow a more centralised and structured prevention and awareness training and permission to go into all prisons.

The Slawek Foundation works in several Polish prisons. The foundation visits and provides support for prisoners and provides a link to services in the community after release. It is financed by the Ministry of Justice, which covers basic costs; all other additional costs are raised by gifts and sponsorship. In prison they provide the 'Atlantis' project for alcohol dependents. The project works in fourteen prisons.

In Romania the researcher visited Rahova male sentenced prison in Bucharest and Târgșor women's prison. The prison hospital at Rahova and Hospital No.9 were also visited. The NGOs that were visited were ARAS and ALIAT.

Rahova prison has a capacity of 2,500 prisoners. The prison accommodates mainly maximum security male sentenced prisoners with sentences longer than ten years, juveniles (aged between 14 and 18) and has a section for pre-trial women prisoners. Mothers are permitted to keep their children with them for a year in the prison hospital if they give birth while in prison. The majority of the women in the prison are there due to drug trafficking offences (Prison Director, Rahova prison 2004).

Târgșor women's prison has 600 women prisoners and 30 male prisoners. This is the only prison specifically for women in Romania although there are women's sections in other male prisons. The majority of the prisoners are sentenced, but there are some pre-trial prisoners. The women here come from all over Romania and this can cause problems because of the distance they are from their families.

As stated, the NGOs visited were ARAS and Aliat. ARAS (Romanian Association Against AIDS) is a national, non-governmental, apolitical and humanitarian organization. Its key aim is to stop the HIV/AIDS epidemic through the development of educational, informative, communication programmes and to offer social assistance services for people living with HIV/AIDS and their families. ARAS coordinates the Romanian Harm Reduction Network, and one of the members is the Independent Medical Service from the General Directorate of Penitentiaries (Romania). Since 1999 ARAS has developed a harm reduction programme for IDUs involved in commercial sex. ARAS also works to raise the

awareness of officials and policy-makers of the importance of mobilizing the human and financial resources that are required by public health. In addition, ARAS tries to create a network and to establish partnerships with similar organizations that are developing HIV prevention programmes in Romania. ARAS runs a wide variety of projects, one of which is working in prisons.

Aliat offers a needle exchange service based in the grounds of the psychiatric Hospital No. 9. The office has two staff members who give information and packs of needles and condoms (when they have them) to injecting drug users. Eighty per cent of their clients are men. Aliat is also a member of the Romanian Harm Reduction Network.

Research in Slovakia included visits to three prisons: Trenčín prison hospital with its semi-open department, Sučany–Martin Juvenile prison and Bratislava pre-trial prison. A brief visit was also made to Ilava high security prison where prisoners with life sentences are housed. Trenčín prison hospital provides 156 beds and a range of medical procedures are carried out. The prison hospital accommodates both male and female prisoners. There is a semi-open prison (under the management of Trenčín prison hospital) that has a drug free zone that is located five kilometres from the hospital.

Sučany–Martin Juvenile prison has a total of 248 prisoners of whom 93 are juveniles; the rest of the prisoners are 18 to 25 years. The juveniles are kept separate from the older prisoners.

Bratislava prison is intended for pre-trial prisoners but there are a few sentenced prisoners who work e.g. as cooks in the prison. Prisoners, once they have been sentenced, come to this prison for the assessment period prior to being sent to a sentenced prison. The population of the prison at the time of the visit was 650 (January, 2004) and it is currently over-crowded. The number of pre-trial prisoners has increased by 50 per cent recently. Ilava High Security prison had 493 prisoners (January, 2004) and an official capacity for 600. Prisoners with life sentences are kept here.

The Prison Service does work with NGOs but not with those offering drug services. The NGOs that are active in prisons are those offering education and training courses and re-socialisation programmes. There are thirteen church groups who come into the prisons and priests who work in the prisons are part of the prison staff and paid by the Prison Department. The Prison Service approached NGOs working with the Romany community to work in prisons also but this was not a successful initiative.

One of the NGOs visited was PRIMA, which is involved in the prevention of addiction and in primary prevention. PRIMA is involved in several projects and has received funding from the Open Society to provide a needle exchange. The main target groups for PRIMA are active drug users, the homeless and prostitutes. Currently, PRIMA is not working with the prison service.

Odyseus was the second NGO visited. They provide an outreach needle exchange and social assistance (providing the contact between the target groups and the health institutes) where they will accompany clients to health facilities. Staff at Odyseus argued that there is a need for a network of institutions to provide services for clients. Currently there is a lack of psychologists, testing facilities, social services for the high level of need. In addition, the staff in these health

institutions are often prejudiced against drug users. In general public opinion is negative towards drug users. At the time of the visit Odysseus was not working with the prison service although some initial meetings have been held with the head of health care at the Prison Service Headquarters in Bratislava.

Research in Slovenia included visits to Ljubljana and Dob prisons. The NGOs that were visited were Skala Youth Street Education, Areal and Stigma. In addition interviews were held with Joze Hren from the Government Office for Drugs⁷ responsible for the national drug programme.

Ljubljana prison is spread over three locations and it is the most overcrowded prison in the country. It has a capacity of 128 but in September 2003 held 223 prisoners. The prison is for male prisoners, including pre-trial prisoners and those sentenced for a misdemeanour. There were 95 remand prisoners and 118 sentenced prisoners in the prison (Prison Director, Ljubljana prison 2003). Dob prison has a capacity of 289 but at the time of the visit had 364 prisoners. The prison is for adult males sentenced to more than eighteen months, 'including a semi-open department (Slovenska Vas) and open department (Hotemez) on an adjacent site' (Walmsley, 2003:503).

The national prison administration is considered to be generally very open to cooperation with the community. SKALA Youth Street Education NGO was created in 1995 and works with young people. They see about 200–250 young people every week. There is a 'programme street 1' where the work focuses on the young people (then moving onto the family). SKALA does not work directly with prisons or prisoners, but conducts prevention activities (encouraging young people to finish their studies and others to find work), family therapy and public relations. As they work on the street they meet drug users and those linked to prisons.

AREAL NGO started in 2003 with the aim to provide a shelter for drug users. At the time of the visit AREAL had twelve clients and staff hope to eventually have up to fifteen. The shelter caters for drug users living rough on the streets and provides one room for methadone clients and two other rooms for drug users.

The Association for Harm Reduction STIGMA NGO used to be part of the *Robert Foundation* that works with HIV-positive people. Currently, the Association for Harm Reduction STIGMA has only three staff and they are in the process of setting up as an independent NGO. They receive financial support from the Ministry of Labour, Family and Social Affairs, Health and the Government Office for Drugs. When Stigma was part of the Robert Foundation staff visited drug users in prison who were mostly clients they had already been in contact with in the community. They also worked with prisoners they had not previously met. The same experts who worked under the Robert Foundation now work in the new NGO. Their prison work is mainly at Ljubljana prison for two hours twice per week. They organise meetings on request in other prisons as well. For example, two members of staff work in Ig prison twice a month. No other NGOs work in prison because of a lack of funding, although prisons are now open and welcome NGOs.

7 The structure of this office will change during 2004, when this office will become part of the Ministry of Health.

Chapter 2

Overview

HIV infection rates among prisoners in many countries are significantly higher than those found in the general population. Prisoners can enter prison already HIV-positive and can also be at risk of becoming infected while in prison due to sharing needles to inject drugs and unprotected sex. Other health conditions that are over-represented in prison populations include substance abuse, other infectious diseases, mental illness, chronic disease, and reproductive health problems (Freudenberg, 2001).

As early as 1993, WHO guidelines on HIV and AIDS in prison stated that ‘all prisoners have a right to receive health care....equivalent to that available in the community’. However, research has shown that HIV prevention and management of care in European prisons are still inadequate in terms of dealing with risk factors and providing information to prisoners (Bollini, et al, 2002). For example, health professionals in prisons should have full access to prisoners’ health records, and yet research has shown that in the UK, information technology to achieve this was lacking in some prisons (Anaraki et al, 2003). The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has set out guidelines for prison health, also with the underlying principle being that of replicating provisions in the wider community, such as access to a doctor, equivalence of care, patient’s consent and confidentiality, preventive health care, humanitarian assistance, professional independence and professional competence. It states that:

an inadequate level of health care can lead rapidly to situations falling within the scope of the term “inhuman and degrading treatment” (CPT 2003).

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has set out guidelines for treatment for problematic drug and alcohol users, who are at greater risk of contracting HIV and other infectious diseases. Often, as a result of drugs misuse prior to incarceration, inmates are already carrying infectious diseases. However, the implementation of services to treat HIV/AIDS and drugs misuse within both prisons and the community varies and is subject to a country’s socio-economic circumstances, cultural attitudes towards HIV and drugs and existing resources. This may determine whether or not preventative measures (e.g. clean needles, condoms) are in place and to what extent these services will impact on the risk levels of spreading infectious diseases. The prevalence of sexual activity in prisons needs to be acknowledged and addressed in order to prevent further infection within prisons, and subsequently, the wider community. Prevention and treatment initiatives have a lot of barriers to overcome in terms of cultural attitudes toward sex, especially homosexual activity, as well as having resources available to deal effectively with the problem.

Therefore, it is against this backdrop – of rapidly increasing HIV infections, sharply contracting public health resources and wild extremes of economic transition – that national responses to HIV and the provision of health care in the region must be measured.

Drugs use in central and eastern Europe

The European Monitoring Centre for Drugs and Addiction (EMCDDA) report (2003) on drugs use in Europe emphasises the impact of the changes occurring throughout central and eastern Europe, i.e. the break up of the Soviet Union in 1991 and the expansion of the European Union (EU). For some central and eastern European countries (CEECs) a sharp decline in employment and the dissolution of agricultural and industrial economies have led to a decrease in the standard of living, rising poverty and crime levels – indicated by increases in prostitution, drug trafficking, human trafficking, organised crime and acquisitive crimes often associated with drugs misuse. Greater transparency has provided a much clearer picture of the prevalence of drugs use, especially for former Soviet Union countries where previously, the drug phenomenon was ‘played down’ and ‘associated with the ‘decadence’ of western countries’ (EMCDDA, 2003).

Prevalence, patterns and trends

Alcohol remains the most widely misused drug through the CEECs, but there are indications of increased use of cannabis, heroin, ecstasy and cocaine. Throughout the 1990s this was attributed in part to the changing lifestyles and consumption patterns of younger generations and those who were ‘marginalised from the wider process of social change’ (EMCDDA, 2003). The need for prevention and treatment programmes was not recognised as a priority and previously drugs misuse has been dealt with in a repressive and coercive manner by governments with little or no provision of services from other organisations. Consequently, CEECs were ill-equipped to deal with the increasing prevalence of problematic drug and alcohol users.

The US Embassy (2002) has presented detailed reports on the patterns of drug trafficking and use throughout Europe. For many countries, a particular concern is the increased use of heroin (Hungary, Latvia, Lithuania, Poland and Slovenia), especially when injected, as this has led to an increase in HIV/AIDS and other infectious diseases (Latvia, Lithuania). The increase in drugs misuse seems to be largely among younger generations, especially students using ecstasy (Hungary) and among more affluent youths there is increased cocaine use (Bulgaria) and a general increase in the use of other drugs (Hungary, Poland). Drug-related crime has also risen, in terms of increased opportunities for trafficking in many CEECs, but also in terms of acquisitive crime (Estonia, Latvia, Slovakia).

Strategies to deal with drugs use and trafficking

For some countries, a lack of infrastructure means their response to drugs trafficking is inadequate in terms of poor interagency co-operation or a lack of protection for victims and witnesses (e.g. Bulgaria, Poland and Slovakia). For others, the response is to toughen sentences for both users and traffickers either in terms of the length of incarceration or widening the net to include anyone involved in the use or production of drugs (e.g. Estonia, Hungary). Strategies to deal with drugs trafficking and use also include protecting witnesses to encourage them to testify or confiscating illegally acquired assets (e.g. Czech Republic), but for most of Europe, there are also resources targeted at treatment and prevention. For example, educating young people in schools about the dangers and consequences of drugs use is included in many countries' plans to tackle rising drugs misuse (Bulgaria, Estonia, Latvia, Poland and Slovenia). Counselling services and confidential health care is also promoted as a way of reducing the use of drugs and the harm they cause (Hungary, Lithuania), as well as detoxification centres (Romania). Teenagers and students are also targeted with information campaigns and advice, often through non-governmental organisations (NGOs), e.g. Estonia, Hungary and Latvia (US Embassy Reports, 2002).

Risk factors

The risk factors associated with problematic drug use are evident throughout Europe and have a significant impact on young people who live in deprived areas, those who come from dysfunctional families and also those from affluent areas who are exposed to the drugs culture through their lifestyle (EMCDDA, 2003). For adults, similar problems have been identified as increasing the likelihood of problematic drug use, along with poor housing, poverty, poor healthcare, little or no education and lack of options which make drugs use and crime associated with it seem like the only realistic options open to them. Individual factors include mental illness (such as depression or anxiety) and a history of sexual abuse. The increased availability of drugs such as heroin, in conjunction with these factors, also plays a role, with increased migration and for more affluent groups, greater disposable income and exposure to the 'drugs culture'.

Drugs use in prisons

Prisons contain a number of problematic drug users that is disproportionate to that in the wider community. One of the factors contributing to this is a growing trend throughout Europe to view drugs use and possession as a criminal offence (rather than an administrative one, with mitigation to decide on the appropriate punishment), particularly among EU acceding and candidate countries (EMCDDA, 2003). The criminalisation of drug misuse throughout Europe has led to a growth in the proportion of prisoners who are also problematic drug and alcohol users,

and therefore vulnerable to further problems exacerbated by incarceration. As in the community, drugs are misused mainly by the deprived and socially excluded and their activities are thought to undermine the ‘foundations of the penal rehabilitation system.’ Drugs misuse is seen as one of the three main health problems currently facing prison systems throughout Europe, with an increase over the last two decades stemming from poverty, increased migration, violence and repressive legislation against drugs misuse along with overwhelming acceptance of custodial sentences. Injecting drug users are less likely to inject whilst incarcerated, but when they do, are more likely to share equipment (EMCDDA, 2001).

The World Health Organisation (WHO) guidelines state that prison is intended to remove a person’s freedom, but not their dignity, autonomy, health or welfare. Prisoners will more than likely have low self esteem, poor mental and/or physical health and little or no education (WHO & CoE, 2001). It is clear that prison is detrimental to good health, in terms of stress, lack of privacy, poor hygiene, overcrowding and a lack of social support (Goos, 1997). Therefore, prisoners become less able to deal with and address their offending behaviour, as they lack the capacity to make decisions that will prevent them from offending – which may include drugs misuse. This also makes them vulnerable in terms of exploitation by other prisoners (EMCDDA, 2001). It is possible to see how substance abuse, poor mental health and communicable diseases are viewed as the main problems facing penal systems, but also that they are inextricably linked and in order to address these problems there needs to be a more holistic and consistent approach. Being incarcerated has been shown to foster drugs misuse in inmates who were previously non-users (Rosenthal, 2000) and injecting drug use will often lead to an increase in infectious diseases such as HIV, hepatitis C and tuberculosis. Drugs misuse itself brings other risks, such as mental health problems and exposure to violence and exploitation from other prisoners.

The WHO guidelines must be taken in the context of a country’s legal, economic and cultural circumstances, and must also take into account the diversities and differing needs of the prison population, which will require a multi-disciplinary approach. Prisoners come from the community and are returned to it, so public health is affected by the provision of health services in prisons (WHO/CoE, 2001). Research from the US has illustrated the negative impact of prison health in the community, especially on urban populations, and the need to link prison service health provision to community services after release, in order to reduce the ‘adverse health and social consequences of current incarceration policies’ (Freudenberg, 2001).

Patterns of drugs use in prison

The specific nature of drugs misuse in prisons raises concerns since, though some studies have shown a decline amongst those already using drugs, incarceration does not stop drugs use, it seems to simply slow it down. Lack of availability plays a large part in this, and will lead to some prisoners using whatever they can find, so there is likely to be a shift from hard to soft drugs and in some cases, soft to hard i.e. cannabis to heroin. The routes of administration for drugs misuse

vary and, although most smoke their ‘drug of choice’, a significant proportion inject and are very likely to share needles, which spreads infectious diseases such as HIV and hepatitis C. There is also evidence that prisoners will start to use drugs whilst in prison – the risk factors are exacerbated by lack of privacy, social support and intimidation or bullying from fellow prisoners. Although this is a small number, it represents a group of prisoners who present further difficulties in terms of their rehabilitation and resettlement on release (Pompidou Group, 2000).

Sexual activity in prisons

The impact of sexual activity in prisons is evident in the prevalence of infectious diseases in prison, and the nature of such activity could contribute to this, in terms of sexual coercion. This remains under-reported within the prison system, and is often perpetrated in conjunction with blackmail, violence and in exchange for goods (Banbury, 2004).

One of the biggest obstacles to dealing with the consequences of sex in prisons is the lack of an acceptance not only that it is a problem but that it exists at all. The denial among prison authorities, staff and prisoners themselves impedes any measures to counteract the problems that arise. For example, the spread of infectious diseases can be prevented in some way by the use of condoms that can be made readily available to prisons. However, the cultural attitudes both within prison and the wider communities towards sex (especially homosexuality) mean that safe sex measures are not widely accepted as necessary and in fact, are an idea that both prisoners and staff are often very much against (MacDonald, 2001). Attitudes towards sex vary from country to country, depending on existing cultural attitudes and therefore safe sex strategies can have an impact. However, this is where another obstacle can arise in the form of limited resources and budget constraints – for example, condoms may not be readily available to all prisoners.

Spread of infectious diseases

Newly independent states (i.e. from the former Soviet Union, such as Belarus, Russia and Ukraine) have had restrictions on travel abroad lifted and one negative consequence of this is a ‘growing epidemic’ of those infected with HIV/AIDS. This will inevitably impact on the economy, in terms of the need to increase healthcare provisions and large numbers of the population unable to work and also the need to recognise that finding a solution to this problem goes beyond providing medical treatment, such as harm reduction strategies, increasing awareness through education and lessening the stigma of living with HIV/AIDS. The disparities in what some countries are able to provide reflects their economic status, but also, cultural barriers to accepting that there is a problem and a lack of infrastructure to implement the many and varied treatment

programmes available elsewhere (Guarineiri, 2003). The increased risks of the spread of infectious diseases to the general population throughout central and eastern Europe are not only reflected in prison, but are often even more of a problem, due to denial that such problems exist, lack of treatment available to prisoners (stemming from a zero-tolerance approach to drug use in many prisons), lack of resources to implement reduction and prevention strategies and prisoners own motivations and attitudes.

Numerous studies have shown that for CEECs, higher rates of HIV/AIDS exist in prisons compared to the general population (Lines, et al, 2004; WHO & CoE, 2001). This increased risk is attributed to the sharing of injecting equipment and unprotected sex, and is often exacerbated by high rates of hepatitis C and tuberculosis (Lines et al 2004). This not only presents risks in terms of the impact on prisoners' health but also impacts on the communities they come from (and are often released back into) and on the prison staff.

There is now a 'unique opportunity to address these health issues while also addressing the causes of offending behaviour' (WHO & CoE, 2001) in that lessons can be learned to prevent the relentless spread of infectious diseases and to reduce the number of problematic drug users in prison. Governments have a 'moral and ethical obligation' to take preventive measures and treat HIV/AIDS infected prisoners as they do for the general population (Lines et al, 2004) under national and international laws; therefore by not addressing this issue they are disregarding the human rights of prisoners and may be subject to the legal consequences of this.

Treatment for problematic drug users in prisons

Research has shown that in many CEECs treatment for problematic drug users is sporadic and many prisoners are not eligible for any sort of treatment or support. Again, the range of treatments available and how well they are implemented varies from country to country, with most European countries developing their policies in the last decade, e.g. Cyprus, Portugal, Romania and Slovakia. Others had policies in place prior to 1990; however the aims and nature of these policies vary in terms of whether they provide harm reduction strategies, treatment and prevention and post-release support. The providers of drug treatment services in prisons also vary – for most countries it is the prison service, but many countries also use community-based services and specialist drug services, as well as probation and, to a lesser extent, non-governmental organisations.

In the United Kingdom good quality treatment has been shown to be effective in reducing re-offending, as long as it provides ongoing treatment and support, post-release care and meets the individual needs of prisoners (Ramsay, 2003). Research has illustrated throughout Europe that prison-based drug misuse treatment can work, and indeed it presents a unique opportunity to reach large numbers of 'clients.' However, improvements can be made in terms of the implementation of the treatment and provision of ongoing support and aftercare.

Prevention and treatment for HIV/AIDS and other infectious diseases

Throughout Europe there exists a variety of strategies for preventing and treating infectious diseases outside prisons in the community. Problems arise in attempting to implement health care strategies in prisons, either due to denial that a problem exists, budget constraints or stretched resources due to overcrowding (MacDonald, 2001). Research has also shown that within prisons, sexual activity and drugs use (specifically, amphetamines) are linked and therefore present further high-risk behaviours that need to be addressed (Kall & Nilsson, 1995). Whatever their sexual orientation, through the use of drugs and unprotected sex HIV-positive individuals may engage in risky behaviour that may place non-infected individuals at risk of contracting the virus (Stephens *et al.*, 1999).

WHO and CPT guidelines emphasise the need for preventative treatment through the use of information campaigns, as well as voluntary testing programmes, that maintain prisoners' confidentiality. CPT also states that 'there is no medical justification for the segregation of an HIV+ prisoner who is well' (CPT, 2003). Prisons in the newly independent states have been described as:

foci for the development of high levels of drug-resistant communicable diseases. (Bollini, 2001)

This presents further difficulties in trying to prevent the spread of infectious diseases in prison. In the wider community and society this constitutes a threat to public health.

Currently, treatment for HIV/AIDS includes education, HIV counselling and testing, acknowledgement of both consensual and non-consensual sexual activity, harm reduction techniques (bleach for cleaning needles, needle exchange programmes), detoxification and methadone maintenance programmes. All of these strategies require resources in terms of medical supplies, trained staff, education materials and an acknowledgement and acceptance that a problem exists.

Education

Educating prisoners about drugs misuse and its risks takes the form of written materials that are distributed and made available in all languages and forms that prisoners can understand. It is also recommended that prisoners and staff should participate in developing educational materials (Bollini, 2001). Prison provides an opportunity to provide education to multiple at-risk populations in a setting that better ensures that all prisoners are reached or at least are given the opportunity to increase their awareness (Stephens *et al.*, 1999).

HIV counselling and testing

There is a recognition that prison health services must replicate what is happening in the wider community. The WHO *Guidelines on HIV prevention and management in prisons* state:

Voluntary testing for HIV infection should be available in prisons when available in the community, together with adequate pre- and post-test counselling. Voluntary testing should only be carried out with the informed consent of the prisoner.

Sexual activity

Preventing the spread of infectious disease through sexual activity is largely achieved through the distribution of condoms. However, problems occur in the availability of resources to do this adequately and also in the case of non-consensual sexual activity. Sexual abuse in prisons is often associated with violence. The distribution of condoms will therefore have little impact because such activity will not be reported or acknowledged among prisoners or staff. Therefore, prison authorities also need to provide a safer environment and take measures to combat aggressive sexual behaviour such as rape (by making it easier for prisoners to report such incidences and maintain confidentiality). They also need to provide a confidential counselling and support system, and deal with the 'goods' trade within the prison, to eliminate it as a means to intimidate prisoners (Bollini, 2001). The extent of male rape in prisons has been debated but research in the US has shown that there are significant number of inmates who are raped and therefore at greater risk of contracting infectious diseases, such as HIV. Aside from the impact on the individual, there also exists a threat to the community, once these prisoners are released – particularly if they have not had the support they required in prison to establish and address their HIV status (Robertson, 2003).

Harm reduction

Harm reduction techniques are based on an acceptance that a problem exists; they represent a move away from 'zero tolerance' mentalities that do not address the stigma surrounding drug misuse/HIV infection or the underlying causes. Strategies such as syringe exchange programmes (SEPs) demonstrate the impact of acknowledging prisoners' right to treatment; whilst ensuring that while they continue to use drugs, they are not spreading infectious diseases. SEPs have been shown to be feasible in terms of their implementation and efficient and effective in that they do not increase injecting drug use and are not misused by prisoners. In conjunction with other measures, they form an important part of reducing the harm caused by drugs misuse; however, as with other measures, they need to be accepted by prison authorities and given the appropriate resources and management to be delivered properly (Stover & Nelles, 2003). Harm reduction has also

been shown to be required to reduce rates of co-infection, i.e. exposure to HIV, hepatitis C, syphilis and other diseases, particularly among injecting drug users (Pallas et al, 1999). The high prevalence of HIV infection among prisoners indicates that prevention measures have not been effective in reaching marginal groups, which are often over represented in prison (Martin et al, 1998).

Providing liquid bleach is another strategy to reduce the risk of HIV transmission, together with instructions on its correct use to sterilize needles and syringes. As with many harm reduction measures, such a strategy is opposed on the grounds that it condones drug abuse by accepting it occurs and not using coercive measures to stop it. There are also concerns about encouraging non-injecting drug users to experiment or to use the bleach as a weapon against staff – this has been shown from experience to be unfounded. Harding and Schaller (1992) found that prisons adopting this as a strategy have continued to use it, with no grounds for ceasing its use. In fact the availability of bleach in prisons in Europe has grown from 28 per cent in 1992 to 50 per cent in 1997 (Bollini, 2001).

Methadone maintenance programmes

The effectiveness of methadone maintenance programmes has been demonstrated outside prisons in terms of reducing the risk of contracting HIV and of overdosing and reducing overall use and criminality associated with heroin addiction. However, for those who are on a methadone maintenance treatment and forced to withdraw because they are incarcerated, there is evidence that they will return to problematic drug use, which increases the very risks that the methadone programme was trying to reduce (Bollini, 2001).

The expansion of drug treatment options and education about drugs in the wider community must be replicated in prison in order to tackle not only the problem that caused incarceration in the first place but also the consequences in terms of the increased spread of infectious diseases. Other treatment options include, abstinence-based programmes, self-help groups, peer education, relapse prevention and other substitution (e.g. Buprenorphine) prescriptions. Indeed, it has been shown that peer-led programmes (education, counselling etc) are particularly effective with prisoners (Bollini, 2001).

The higher rates of drugs misuse in CEECs are not only reflected in the prison populations, but are in fact greater in the prisons and therefore the risks associated with it increase, such as the prevalence of HIV and other infectious diseases. Unprotected sex and a lack of measures to prevent such behaviours exacerbate the problem, as do economic constraints and cultural attitudes. For CEECs, lessons from western Europe and the US can be learned in terms of implementing preventative measures to control the spread of infectious diseases within prisons and therefore the community. The most effective so far include educating prisoners about the risks, harm reduction techniques and addressing drugs misuse in prisons through treatment services, as opposed to segregation and further punishment (Inciardi, 1996). Prison authorities must think beyond their role as incarcerators and address the adverse impact of current policies in order to prevent a prison health crisis inevitably becoming public health crisis.

Chapter 3

Health care, drug use and communicable diseases in the community in the sample countries

The drug services provided for problematic drug users in prisons in the ten countries will be examined. However, before doing so, it is useful to look at some of the factors in the wider society that have an effect on the prison administrations in each of the countries. These factors also provide a context within which to place the problems that are facing the prison administrations in meeting the health care and drug services needs of their prison populations. The extent of drug use and communicable diseases in the wider communities of the ten countries will impact on the composition of their prison populations, with potentially more drug users ending up in the prisons. Ideally, health policy and provision in prison should be integrated with national health policy, ensuring close links with communicable disease programmes: for example, the reporting of cases of TB identified in prison and the facilitation of continuing treatment and follow up of released prisoners. Thus it is helpful to look briefly at the provision of health treatment in the community of the ten countries in the research.

Health care and communicable diseases in the community

The reform of the National Health Care System in Bulgaria is important in how it impacts on services for drug users (treatment and rehabilitation). The National Programme for Prevention, Treatment and Rehabilitation of Drug Addiction has as one of its key aims the reform of health care for drug addiction and drug related problems. Drug users will benefit from three components of the National Health Care Reforms. The first is the enhancement of the role of General Practitioners⁸ (GPs) to improve medical and other services to problematic drug users. One component of the GPs' role will be to provide education about prevention, early diagnosis of the use of drugs and early intervention for patients with drug problems and their families. The second is an evaluation of *The Health Insurance Act* regarding its accessibility to drug users. This evaluation has come

8 Also known as family doctors who are the first point of contact for patients prior to referral to specialist doctors.

from the concern that drug users will not be covered by health insurance as a result of being unemployed, not registered at the unemployment offices and not insured by their families. The third component is the reform of psychiatric health policy that will impact on how drug users are treated. In May 1998 the Bulgarian government collaborated with the United Nations Development Programme to create a National HIV/AIDS strategy. The creation of the strategy involved health care workers, government and non-government organizations, educators and social workers (United Nations Development Project, 2001).

Health services in Bulgaria currently meet WHO and EU standards. However, UNDP feels that the centralized medical services will not be able to deal with an increase in the number of HIV/AIDS cases. All those with HIV/AIDS who meet the Centres for Disease Control and Prevention (CDC)⁹ criteria are offered free treatment using antiretroviral drugs and free hospital treatment (United Nations Development Project, 2001).

The health system in the Czech Republic is funded by health insurance. Five million policyholders (those most likely to need access to health care) are paid for by the State, for example pensioners, mothers, children, and sector workers. All health insurance companies in the country are independent but non-profit-making. The Czech Republic Charter of Fundamental Rights and Freedoms provides citizens the right to health care:

including the right to free medical care and medical aids under conditions set by law. In 1988, the law defining Methodological Directives to ensure a uniform procedure for prevention of AIDS was passed. This law lays down the procedures for compulsory notification of all detected cases of AIDS, ARC, PGL and HIV-positive persons and also the prohibition on HIV/AIDS positive blood donors. In addition, special procedures for screening high risk populations were set forth, and the importance of educating health workers was emphasized. (Drug Law and Health Policy Resource Network, 2001)

Reform to the Estonian health care system occurred at the end of the 1980s, involving two major changes away from a centralised and state-controlled care delivery system to a decentralised system, including private provision based on health insurance. The main reasons for reform were that:

- there was no relationship between health care expenditure and the national economy;
- the health care system had too much hospital capacity and too many specialist-doctors for the needs of the Estonian population;
- alongside over-capacity in the secondary and tertiary care sectors there was a disproportionately weak and underdeveloped primary health care system. (<http://www.medicover>)

9 The Centres for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of people – at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships.

In 1995 the public health system was reorganised (Public Health Law 1995) and this established the structure, finances and function of public health. The key priorities for health care in Estonia are:

- to launch public health programmes to promote health on both state and local level;
- to improve the health insurance system efficiency, planning and management;
- to continue the reduction of the number of hospitals whilst improving techniques and technologies;
- to continue with the reforms towards improving the quality of health care. (<http://www.medicover>)

In common with other countries in the CEE region, health care is under-funded and results in waiting periods sometimes of three to four months to see a specialist.

Commentators on the Hungarian health system argue that it is resource heavy, characterised by high hospitalisation rates and too many specialists. Recent reforms to the system have involved attempts to improve service delivery and health outcomes in a context of institutional conflict. In order for continuing reform to be successful:

emphasis needs to be placed upon measures that support health promotion, while concerted changes are needed at the financial, legal and organisational levels, in order to ensure that decision-makers are held accountable and that the authorities are in a position to monitor them. Finally, more emphasis needs to be placed on increasing home-based care, occupational and physiotherapy services and on making greater use of nursing homes, as opposed to chronic-care hospital beds. (Orosz and Burns, <http://ideas.repec.org/p/oed/oecdec/241.html>)

The primary health concerns in Latvia are similar to those of other central and eastern European countries that were formerly satellites or constituent republics of the Soviet Union. Aggregate health indicators have deteriorated compared to the pre-transition period, leaving Latvia with a significant gap in health status in comparison with the European Union countries which Latvia joined on 1 May 2004. Due to a lack of effective public health policies and programmes, the health system does not proactively address the root causes of ill health (The World Bank Group, 2003).

The way that health care in Latvia is structured has changed since independence from the Soviet Union in 1991. The Ministries of Health, Labour and Social Welfare were merged into the Ministry of Welfare in 1993. In 1998 the state compulsory health insurance agency was re-established. The government's chief emphasis is on the development of primary health care, based on general practice in a decentralised system, with an expanding role for local government structures (Drug Law and Health Policy Resource Network, 2002).

Lithuania inherited a model of health care provision typical for the former USSR:

This was over-centralized, had little room for patient choice or respect for patients' rights. There were too many beds, shortages of drugs and little attention to primary and social care. In the health sector, wages and morale were often low. On the other hand, medical facilities were quite evenly distributed throughout the country, public transport was relatively well developed and financial barriers to health services (even including under-the-table payments) were low. Basic vaccinations covered the whole population and communicable diseases were adequately controlled. (European Observatory on Health Care, 2000:73)

During the last ten years, the key reforms to the health service have been the introduction of public funded health insurance (financed through a combination of insurance contributions and tax revenues, with a larger share of the latter) and the re-organising of health care institutions (European Observatory on Health Care, 2000). By the end of 2001 the health care system (excluding private institutions) consisted of 189 hospitals, 440 outpatient clinics and 966 rural medical aid posts. During this same period there has been a rapid growth in the number of private health care institutions.

The health reforms in Poland began in the 1980s with the start of the decentralisation of health care. There has been a gradual phasing out of the taxation-based funding of health care to one based on health insurance. There has also been some privatisation of health care provision in pharmacies, dental provision and private medical practices. The 1991 Health Care Institutions Act enabled reform to the health care provision and the Ministry of Health and Social Welfare:

became responsible for the health policy, training, research and specialised facilities, while regions became responsible for organizing and financing tertiary care and local governments became responsible for primary and secondary care. (WHO, 2001)

The reform of health care provision and the introduction of health insurance has not been without problems, due to the lack of a centralised register of persons who have insurance, unequal payments amongst the population, not all people being covered by the scheme and economic problems with the state run scheme. ((Vogler and Habl, 1999). In addition it has been argued that:

the quality of health care services is said to vary by region. There are also other problems: the poor organisation of primary health care has led to queues and long waiting times, and insufficient medical equipment has led to dissatisfied patients and to low morale among health care personnel. There are also fears that the best-educated physicians may prefer private practice instead of public service. (Vogler and Habl, 1999)

Three institutions currently play a major role in the organisation of the health care system in Romania: the Ministry of Health and Family (formerly the Health Ministry), the Doctors' College in Romania (founded in 1995) and the National

Fund of Health Insurance (established in 1998). Primary assistance is based on the family doctor, who is an independent professional practitioner and can guarantee access to medical services. People not earning a steady income (i.e. children, youth, retired persons and military conscripts) have free access to public health services. The Health Insurance Fund pays for medical services (National Human Development Report, 2001–2002).

In order to access all medical services, people in Romania are required to have medical insurance. To be insured, people must have identification papers, must prove that they pay health insurance and that their employer also pays their contribution. People under 18 years old, high school and university students, people with disabilities, retired persons and the spouse of a person who is insured (if they do not have their own income) are all automatically covered by health insurance. Those who do not have medical insurance only have access to emergency health care and health services for communicable diseases¹⁰. A problem for the delivery of medical support is the critical condition of many hospitals today, because of a lack of medical equipment and poor infrastructure¹¹.

The key objective of health reform in Slovakia has been to improve the health status of the population. This was to be achieved by:

- Removing state monopoly of health provision
- Introducing private health care;
- Increasing the salaries and social status of health care staff;
- Enabling free choice of health care providers; to implement an economic relationship between health care providers and patients. (WHO, 2001)

In 1992 health care was financed by health insurance rather than being tax-based. Despite ongoing reforms to the health care system, there are still some major problems with the health insurance system (Rusnak et. al. 1998; Vogler and Habl, 1999) and:

legislation in the health care sector has suffered from unclear formulation of health care policy and its goals. The governmental and non-governmental entities do not yet collaborate in the solution of problems. In order to reach high standards of health, effective managerial and financial control mechanisms are needed to implement legislation. (WHO, 2001:30)

Slovenia in 1992 introduced a voluntary health insurance system and began privatising health care facilities and reforming the existing compulsory health insurance system. According to Markoto and Albrecht (2001), key problems with the insurance system have been caused by ‘the introduction of value added tax, increasing salaries for health professionals and higher drug prices’. The organisational structure of health care is that:

central government is responsible for planning, policy and regulation of the entire health care system. It also provides capital funds for the hospital sec-

10 Emergency order of the Government No.150-2002 regarding the organisation and functioning for the health insurance system.

11 Until 1993, the hospital maintenance expenses had been financed by the central budget. Then they were transferred to local budgets. And, more recently they are managed by the County Health Insurance Funds.

tor, with local government providing capital expenditure for primary care. Revenue funding for the health care system is provided by the insurance system. All citizens are entitled to the benefits of compulsory health insurance coverage. The unemployed, who receive public support, are covered by payments from the National Employment Institute and its branches. (WHO, 2001, Highlights on Health)

Drug use

The ten countries are all experiencing an increase in the extent of drug use, often concentrated in the capital city and, in some countries, most notably amongst young people.

In Bulgaria, in the last five years alone, the number of in-patient drug-dependents has doubled, while in the 1990–1998 period their number increased over five times. The current number of heroin users has expanded from a few hundred in the early 1980s to about 50,000 in 2003 (International Narcotics Control Report, 2001; Drug Law and Health Policy Resource Network, 2002). In common with other countries in central and eastern Europe, drug use in Hungary is increasing, particularly among teenagers and individuals in their twenties (International Narcotics Control Report, 2001). There are 10,000 heroin addicts in Hungary, with Budapest having a particularly high drug-usage rate. In Latvia, during 1999, 410 people registered as having a drug dependency. Officials estimate that now there are about 15,000 drug-dependent people in the country (UNAIDS, 2000). In Lithuania, there are more than 3,000 officially registered drug-dependent people. Police estimate that over 30,000 people out of a population of 3.7 million use drugs and half of these live in the capital city, Vilnius (International Narcotics Control Report, 2001). Estimates of the number of ‘problematic drug users’ in Poland, who have regular and problematic use, vary between 32,000 and 60,000.

A study carried out by the Romanian AIDS National Commission (2001) in Bucharest estimates that there are 32,000 injecting drug users (IDUs) out of the city’s population of approximately 3.5 million people (CEENDPS background information, 2003). In the past, Romania was perceived as a transit country for drugs but now, although there are no statistics of drug use at the national level, this estimate of the number of drug users is of concern. However, commentators have suggested that:

although low salaries earned by most Romanians make narcotics too expensive, law enforcement officials noted a trend of increasing domestic drug use. The trend is most noticeable in consumption of cannabis and synthetic drugs such as “ecstasy”, among the nation’s youth. Child drug users often engage in high-risk behaviour. As one filmmaker put it, “Heroin has replaced [the paint thinner] Aurolac. One child can’t afford a syringe, so you will have five kids chipping in for one syringe full and then sharing a needle.” (International Narcotics Control Report, 2001; Sinagra, 2002)

According to official data, Slovakia, and in particular its capital, Bratislava, experienced a rapid increase in problematic drug abuse in the early 1990s, when patterns of drug consumption moved from solvents, hypnotics and sedatives to heroin-injecting. A large increase in the number of treated opiate addicts has been recorded in the country since 1994. Until 1995, most of those treated were residents of Bratislava, but the spread of the heroin epidemic throughout the country has been confirmed by an increased percentage of clients outside the capital (UNAIDS and ODCCP: 2000).

In the Czech Republic in 2001 there were 4,233 drug-related first treatment requests with the average age of clients being 21.3 years. The age of users who request treatment has begun to increase in the last two years. This is considered to be a favourable trend as it signals a decrease in the influx of new problem users. In the early 1990s, drugs became an important social problem in Slovenia; however, due to a co-ordinated response from governmental and non-governmental organisations, the impact of drugs on Slovenian society was stabilised.

The drug of choice varies between the countries but heroin use is the most common. There are a variety of drugs used in Bulgaria, cocaine is too expensive for all but the wealthy, and marijuana is traditionally limited to rural areas. Ecstasy use is growing among university students. Historically, drug consumption is more significant among the marginalized Roma, where glue sniffing is of serious concern. Bulgarian police are concerned about a recent surge in the use of amphetamines by the country's youth (International Narcotics Control Report, 2001).

The most widely used drug in the Czech Republic is marijuana, then pervitin,¹² then heroin (mostly injected). Young people also use ecstasy, MDMA, angel dust, and glue. LSD is rarely used and cocaine is too expensive. Heroin use is slowly increasing and comes mainly from the Balkans. In 2001 there were 2,545 drug users recorded who were using pervitin and 1,362 drug users recorded using heroin. Most use is in Prague and in Northern Bohemia, but heroin is a new phenomenon in Southern Moravia and Southern Bohemia (Psychiatrist, Academia Medica Progenis, 2003).

One of the biggest problems amongst the Russian-speaking population of Estonia is the use of injected heroin or home-made poppy products. Similarly, over ninety per cent of registered drug-dependent people in Latvia report using opiates, with heroin use becoming increasingly widespread. However, a comprehensive collection of data related to substance misuse is not yet fully developed. A survey by the Riga Drug Prevention Centre in Latvia, revealed that 75 per cent of youth in the Latvian capital use drugs on a regular basis or have tried them once, 6 per cent having tried cocaine and 5 per cent heroin (Baltic Times, 2000). In Latvia, illegal drugs, including heroin, are inexpensive. A single dose of heroin costs less than a Big Mac at McDonald's. Drugs are now readily available in

12 Pervitin is an amphetamine and psycho-stimulant. It causes faster thoughts and movement, feelings of greater creativity and of being relaxed. It is mentally addictive and has side effects such as amnesia, psychosis, hallucination, manic disorders and schizophrenia. Pervitin was originally invented for soldiers in WWII. It can be made from different medication, like cough syrup. It is hard to detect in the blood and urine.

Latvian schools. Also, the growing number of street children is expected to lead to an increase in drug use (UNAIDS, 2000).

The drug of preference in Lithuania has changed:

until 1998, the most popular narcotics were cheap local substances, such as locally grown poppies and “Ephedrine”. As the country’s standard of living increased, so did its demand for synthetic drugs. Around 2000, sophisticated laboratories for amphetamine production appeared. As of 1999, heroin became the drug of choice in Lithuania, because it became twice as cheap to purchase in that year — down to five U.S. dollars per dose. (Drug Law and Health Policy Resource Network, 2002)

According to the National Bureau for Drug Prevention in Poland, cocaine use is rare and not very popular. There has been an increase in the use of amphetamines and cannabis. Amphetamines are available in tablets and powder that can be inhaled or drunk. ‘Brown sugar’ heroin is increasingly available, whereas the Polish ‘compot’ (home made from opium straw) is becoming rarer on the streets. It is possible that the poor image of this drug, because of its connection with death and social deprivation, is responsible for this trend (Sieroslowski, National Bureau for Drug Prevention, 2003).

The main drug used by people who have been in the treatment facilities in Slovakia or who have visited the needle-exchange¹³ programme is heroin. In the last year,¹⁴ the outreach workers as well as workers from the Centre for Drug Dependencies Treatment have seen a significant increase in pervitin¹⁵ use. Outreach¹⁶ workers have also observed an increasing abuse of solvents, due in part to the low quality of street heroin and when heroin is not easily available.

The drugs used in Slovenia are similar to those used in other countries in Europe, and are marijuana, heroin, amphetamines, and a small amount of cocaine (Centre for Treatment of Drug Addiction, 2003).

In the ten countries injecting drug use was also very common and this links to the prevalence of communicable diseases. The typical profile of IDUs in Estonia is that they are predominantly heroin users, Russian speakers (who make up about 80 per cent of IDUs), aged between 15 to 25 years old. The number of IDUs across Estonia is estimated to be between 12,000 and 15,000 (Kalikova, 2002). In Latvia, sixty-five per cent of drug-dependants are considered to be intravenous drug users. In addition:

there has been an increase in heroin use among teenagers, who tend to place obtaining heroin over concerns about HIV/AIDS. (Kulagina, 2000; UNAIDS, 2000)

13 Source: Odyseus, Ukrajinska 10, 831 02 Bratislava 3, www.odyseus.sk (web page will be in English from January 2004); information is based on the information exchange at the official meeting of all outreach workers from NEP in the Slovak republic, which are organised by Odyseus.

14 Source: Odyseus; the information is based on the discussions at the official meeting of organisations working in harm reduction in Bratislava (so-called HROBA group) which are organised by Odyseus.

15 Pervitin (an amphetamine) is known as the “Czech drug” even though the country where it was first produced was Germany. Pervitin is based on ephedrine and is in most of the cases home-made. In Slovakia it is significantly cheaper than cocaine.

16 Source: Odyseus; outreach programme Protect Yourself – internal documents.

Injecting in Poland has a bad image and this has led to a decrease in injecting and an increase of multi-drug-use patterns. In Poland, opiates remain the main drugs causing problematic use.

Communicable diseases

The extent of HIV in the ten countries is variable, with high prevalence in some and concern that the disease is spreading amongst IDUs. Even in some of the countries where the rate is still low, there is concern that the conditions are right for a high increase of HIV, especially in marginalised communities. Hepatitis is also of concern in all the countries, but the extent of it is not clearly monitored in every one.

The incidence of HIV in Bulgaria is low, although accurate and complete data on HIV are not available; only 300 cases of HIV have been reported (United Nations Development Project, 2001). There is concern that the public may become complacent about the spread of HIV because of the current low numbers. Current data do not show HIV spreading among injecting drug users, but the social and behavioural conditions are in place for an explosive epidemic of injection-related HIV (European Centre for the Epidemiological Monitoring of AIDS, 2000–01) and 83 per cent of all cases of HIV are by heterosexual contact (UNDCP, 2001). There is also concern that HIV will spread more rapidly in the north of the country and amongst the Roma community. The Roma community are:

isolated and subject to much discrimination. They possess a number of characteristics consistent with the spread of HIV/AIDS. They experience high unemployment, low education, poor health standards and have few outreach programmes. Also, Roma sexual customs contribute to the spread of disease. For example, use of condoms and discussions about sex are socially taboo. Men are allowed to engage in sexual activities, while women are not, putting women at risk. (United Nations Development Project, 2001)

The subject of HIV/AIDS is socially taboo in Bulgaria and due to the stigma and negative societal attitudes attached to being HIV-positive, people are afraid to be tested. This attitude also extends to officials who wish to ignore the subject (Udden, 2001). The spread of HIV is related in important ways to the incidence of other infectious diseases. Non-sterile injection drug use is a risk factor not only for HIV, but also hepatitis (WHO, 2001). Hepatitis B prevalence amongst IDUs is 20 per cent and hepatitis C prevalence is above 50 per cent (International Narcotics Control Report, 2001). Bulgaria appears to be in the midst of a seriously growing epidemic of TB. Syphilis increased significantly between 1993 and 1999, but may be stabilizing (WHO, 2001; 1999).

The prevalence of AIDS in the Czech Republic is concentrated in the homo/bisexual population and is rapidly spreading to the heterosexual population. The number of cases transmitted by injecting drug users (IDUs) remains low; this could be explained by the inadequate methods of tracking and testing incidents

in injecting drug users¹⁷. Since 1998, new HIV infections have increased after a significant drop in reported cases between 1997 and 1998. The stigma attached to being infected with HIV or AIDS in the Czech Republic is considered to be extreme:

those who live in less populated areas are forced to keep their illness a secret and access to treatment is limited. Others who live in cities, such as Prague, are able to remain anonymous, and treatment is more readily available, but the stigma is still present. Despite efforts by activist groups to teach tolerance to the younger generations, those infected with HIV/AIDS are consistently pushed out into the margins of society. (Radio Prague, 1999)

Sources reporting tuberculosis per 100,000 populations (WHO, 2000), show a substantial increase in incidents between 1995 and 1996 in the Czech Republic, where rates jumped from 18 to 19.2. From 1996–1999 the reported cases showed a decreasing trend, resulting in a rate of 15 cases per 100,000. The information that is available (Reitox National Focal Point, 2002) indicates that the incidence of hepatitis B and C virus infection has stabilised during the last three years among the population of drug users where:

among the population of clients of low-threshold facilities, HBV prevalence is around 10%, and it is 40–50% among the population of long-term and severe opiate users in substitution treatment. HCV prevalence among the clients of low-threshold facilities is approximately 35%, and approximately 60% among the population of substitution treatment clients. It is frequently the case that a combination of both of these types can be found among the population of long-term users (40% approximately). (Reitox National Focal Point, 2002:45)

The prevalence of hepatitis B and C among problematic drug users in prison is similar to that among long-term and severe opiate users in substitution treatment in the community, indicating that drug users in prison are at high risk regarding the transmission of HBV and HCV.

Increasing drug-related infectious diseases in Estonia have mirrored the increasing drug problems in the community. According to Nelli Kalikova¹⁸ (2002) from the Estonian AIDS Prevention Centre, the spread of HIV amongst injecting drug users (IDUs) has continuously been rising since 1995. The typical profile of the IDUs is that they are predominantly heroin users, Russian speakers (who make up about 80 per cent of IDUs), and aged between 15 to 25 years old. The number of IDUs across Estonia is estimated to be between 12,000 and 15,000 (Kalikova, 2002).

In February 2001 the Estonian Ministry of Social Affairs classified the growth of HIV as a concentrated HIV/AIDS epidemic (according to UNAIDS/WHO classification).¹⁹ In Estonia, reported infections soared from 12 in 1999 to 1474

17 In the year 2001 there was a very low HIV (AIDS) infection rate in injecting drug users and in the population that does not use drugs (National Focal Point on Drugs and Drug Addicts, 2003).

18 Nelli Kalikova has since become a member of parliament.

19 “Concentrated epidemic” means a disease spread within a specific group, affecting more than 5% of it.

in 2001. Relative to population size, Estonia now has the highest rate of new HIV infections in this region – 50 per cent higher than the Russian rate (UNAIDS, 2002). The HIV virus has spread rapidly among intravenous drug users, particularly in the north eastern city of Narva, which is populated mostly by Estonia's ethnic-Russian minority. Epidemiological studies have confirmed that the most endangered are younger drug users who have only just started injecting and share syringes or even doses (Kalikova, 2000). Most of the people diagnosed with HIV in 2001 were intravenous drug users aged 18 years to 24 years old, with the youngest person to become infected being 13 years old. Seventy-seven of the HIV infections were among prisoners (Estonia-AIDS, 2001).

In 2001 449 cases of hepatitis B (306 males and 143 females) were reported in Estonia (The Estonian National Focal Point and EMCDDA Report, 2003). It was:

the increased cases of hepatitis B and C in 1995–1996 that pointed to the danger of the spread of HIV/AIDS, as the ways of passing them on are similar: dangerous injecting habits, use of common needles. (The Estonian National Focal Point and EMCDDA Report, 2003: 14)

The incidence of TB in the community has declined slightly in 1997 from 44 to 42 per 100,000 population in 2001.

Data from the European Centre for the Epidemiological Monitoring of AIDS in Hungary show that the annual rate of reported newly diagnosed HIV infections is the lowest it has been since reporting began in 1993, with 17 cases among men, of which 3 cases are due to injecting drug use and 14 cases from heterosexual sex (European Centre for the Epidemiological Monitoring of AIDS, 2001). The cumulative total of reported HIV/AIDS cases was:

963 at the end of December 2001, including 258 foreigners, i.e. 26.7 per cent (1 per cent due to injecting drug use; 50 per cent and 15 per cent respectively due to homo/bisexual and heterosexual routes of transmission; remaining cases undetermined). The injecting drug users detected as HIV-positive were foreigners (8), or contracted the infection abroad (2). So far, there is no indication that HIV infections would have occurred as a consequence of injecting drug use in Hungary. The HIV/AIDS control and prevention activities are being carried out mainly by the local, regional and central public health institutions. An Advisory Committee on AIDS was established in 2001. (UNAIDS, Fact Sheet Hungary, 2002)

HIV testing is mandatory for blood donors. A national HIV reporting system has existed since 1985. The spread of HIV is related in important ways to the incidence of other infectious diseases. Use of contaminated injection equipment exposes users to the risk of hepatitis B and C. There has been an increase in the number of hepatitis C infections, especially among young injecting drug users (UNDCP, 2001). In two studies conducted by the National AIDS Laboratory among samples of 333 and 351 drug users, the prevalence of hepatitis B infection was 2.5 per cent and 0.6 per cent, respectively. There has been an increase in

Hungary in the number of hepatitis C infections, especially among young injecting drug users (UNDCP, 2001). The rates of hepatitis C infection were 15.4 per cent and 9.6 per cent, respectively (UNDCP, 2001). The rates for syphilis have remained lower than 4 per 100,000 since 1994. The rates of TB have declined from 1995 to 2000 (WHO Europe Communicable Disease, 2001).

HIV/AIDS is clearly at the top of the Latvian government's agenda in terms of communicable diseases. According to the AIDS Prevention Centre, Latvia's number of new HIV cases dropped by one-third between 2001 and 2002, proving the need to continue recently-begun prevention work in the country (CDC News Updates, 2002). In comparison with 492 recorded new cases of HIV in 1999, in 2002 there were approximately 2,307 recorded cases of HIV in a country of 2.35 million inhabitants (CDC News Updates, 2002). Many young Latvians report that they have never thought about HIV/AIDS. Officials believe this is due to lack of information being disseminated about the HIV epidemic. In part, this in turn is due to a town/country divide. Young people living in the countryside are less likely to have been taught about HIV/AIDS than those who live in urban areas. As one young Latvian said:

youth in Latvia do not have complete and correct information about sexual and reproductive health. Many of us do not know about safe sex and contraception. So many are ill with sexually transmitted diseases and AIDS. These problems affect the future of young people in Latvia. (Drug Law and Health Policy Network, 2002:7)

Voluntary HIV testing and treatment is available for everyone in the country and, paid for by the state, is free of charge to patients. HIV post-exposure for medical personnel and HIV preventive therapy for HIV-positive pregnant women is also free of charge (UNAIDS/WHO, 2002)

Following the disintegration of the Soviet Union in 1991 Latvia, like many former Soviet Republics, faced substantially depleted resources for tuberculosis (TB) control. According to a World Health Organisation (WHO) report, in 2003 there was an estimated total of 1,898 cases of TB in Latvia (Corbett *et al*, 2003). The epidemiological situation regarding TB is critical and treatment of TB is complicated due to a high prevalence of drug-resistant TB. By the end of 1996, the WHO-defined directly observed treatment, short-course (DOTS) strategy was implemented. This was followed by a prison programme in 1998 to treat the (approximately) 200 TB patients diagnosed each year. These efforts resulted in a 30 per cent reduction of the level of MDR TB in Latvia by 1998 (CDC, NCHSTP Program Briefing, 2001).

According to UNAIDS, Latvia has consistently high sexually transmitted disease rates among high risk groups, including young people, intravenous drug users, prisoners, male homosexuals and prostitutes (UNAIDS, 2000).

In Lithuania there is a lower prevalence rate for HIV than in the rest of central and eastern Europe. The prevalence of HIV had two peaks, one in 1994 and another in 1997:

the 1997 peak is thought to be linked to the increase in intravenous drug use. Lithuania's HIV rate is believed to be low, thanks to the early efforts of projects like the Lithuania AIDS Centre. As early as 10 years ago, the project started launching education programs in the schools and community. This is thought to have helped keep the epidemic under control. (Drug Law and Health Policy Resource Network, 2002)

The city of Vilnius has the fastest growing rate of HIV infection amongst injecting drug users in Lithuania. The majority of HIV-positive people are under 30 years old (Drug Law and Health Policy Resource Network, 2002).

The Lithuanian strategic plan for the control of HIV involves prevention measures and fosters co-operation between the various organizations involved in this work.

The prevalence of the hepatitis C virus (HCV) among IDUs is generally much higher than that of HIV. In Lithuania, estimates for hepatitis C among IDUs are 60 per cent and more. In 2002, 437 new cases of viral hepatitis were registered (1.26 per 100,000 population) from which there were 17 new cases of hepatitis A (0.08 per 100,000 population), 274 new cases hepatitis B (0.74 per 100,000 population) and 128 new cases of hepatitis C (0.37 per 100,000 population)(Health Emergency Situations Centre, 2002).

The high incidence of hepatitis C has implications for long-term public health costs:

... at present, responses and treatment options [for hepatitis C] remain under-developed in the region [central and eastern Europe] and need to evolve if they are to have a positive impact on long-term health problems. (EMCDDA, 2003)

The Lithuanian TB Prevention and Control Program for 2001 has been prepared taking into consideration the World Health Organization recommendations. It has also been adapted to serve the needs of the health care system of the Republic of Lithuania. The programme aims to stabilize the spread of TB and to decrease the death rate as well as to protect the population of Lithuania from the infection. The incidence of TB in 2002 was 2420 (69.76 per 100 000 population) (TB Register of Lithuania, 2002).

Poland was the first country in the region to deal with the HIV/AIDS epidemic. Intravenous drug use is the primary source of infection. In 1999, it was reported that about 25,000 people were living with HIV/AIDS. Through programmes that combat the social stigma attached to the disease and the promotion of prevention programmes, Poland has been a leader, in the region, in halting the spread of the disease (BBC News 13/8/1999). The Polish surveillance system for infectious diseases has a long history; it has been in operation since 1918 for some diseases. The Sanitary-Epidemiological Inspection network is responsible for epidemiological surveillance and control of communicable diseases. Sanitary-epidemiological stations collect, analyse and disseminate data at local, regional and nation-wide levels. Physicians are mandated by law to send informa-

tion to the local (county) Sanitary-Epidemiological Inspection authority when notifiable infections are suspected. Standard intervention care is always provided in the case of communicable diseases, and emergency actions are provided in the case of rare and potentially serious infections (Galimska, State Hygiene and Epidemiology Office, Poland)²⁰

Data on the prevalence of HIV among reported injecting drug users (IDUs) for 1995–2001 suggests some stabilisation. In 2001, 0.68 % per 100,000 population were HIV-positive among reported IDUs. Trends for the number of new HIV cases among IDUs show a slight downward trend during the period 1997 to 2001. In absolute numbers, there were approximately 300 new HIV infections per year and this trend has been stable since 1990 (see EMCDDA figures).

During the period 1995 to 1999, the figures show a continuous decrease in the number of cases of TB per 100,000 population in Poland. In a 1996 National Health Program:

a goal to reduce TB incidence by 15% by 2005 was set. That goal has already been achieved. Overall, by the mid-1990s TB rates began to drop below the average of reference countries, yet still remained more than double the European Union rate. (WHO, 1999–2001; Drug Law and Health Policy Resource Network, 2002)

In Poland the incidence of hepatitis C varies significantly. Hepatitis C rates, based on reports published in 1999, reached 1.4 per 100,000 people (World Health Organization, 2001). The incidence of hepatitis C since 1993 decreased by 80 per cent and continues to be lower than the rest of the European Union.

Romania has almost 9,000 HIV-infected children due to certain high-risk factors during the 1980s (i.e. lack of contraceptive measures, sexual education, anti-abortion law and use of non-sterilised syringes). These numbers are expected to rise due to increasing drug use and sexual activity among Romania's 5,000 street children (Fleishman, 1998). So far, the majority of Romania's HIV/AIDS cases have been caused by non-sterile medical equipment and contaminated blood (Drug Law and Health Policy Resource Network, 2002).

At present Romania has a high rate of sexually transmitted infections (STIs). There is compulsory notification of syphilis, gonorrhoea and HIV infections. The incidence of syphilis can be considered a relevant indicator for the trend of STIs. In 2001 the incidence of syphilis was 56 per 100,000 inhabitants, almost treble what it was in 1989 (19.8 per 100,000). However, this is probably an under-estimate, as large sections of the population do not go to the doctor with such complaints.

Social attitudes toward HIV/AIDS are negative in Romania where:

people with HIV are held responsible for the spread of the disease. This leaves children with HIV/AIDS at a special risk of abandonment. Many Romanians think that punishing gay men will stop AIDS. School education

20 Joanna Galimska, State Hygiene and Epidemiology Office, Poland The Network for the Epidemiological Surveillance and Control of Communicable Diseases in Poland.

avoids talking of sexual orientation, venereal diseases and HIV education. (Drug Law and Health Policy Resource Network, 2002)

The Romanian HIV/AIDS National Strategy (2000–2003) prioritises youth, vulnerable and disabled groups, medical assistance and support for HIV/AIDS infected people and epidemiological surveillance. The strategy also includes the development of harm reduction and prevention. The strategy emphasises co-operation with NGOs dealing with needle exchange and information programmes and condom distribution²¹.

Romania appears to be in the midst of growing epidemics of both tuberculosis (TB) and syphilis:

public health is worsening due to poverty, natural disasters and worsening social conditions. The incidence of tuberculosis in Romania is the worst in the region. (Sparrows, 2001)

The National Programme for TB Control (NPTC) 2001–2005 is a part of the National Public Health Programme of the Romanian Ministry of Health. The main objective of the programme is to limit the spread of TB through generalized controlled treatment (medical evaluation, supervision and treatment). The treatment for TB is provided free of charge to encourage all sufferers to come forward. The Ministry of Health and Family makes use of the mass media to inform the population of the need to control the spread of TB²².

In Slovakia the official statistics about HIV/AIDS and hepatitis show a prevalence of hepatitis B of 6 per cent among IDUs and a prevalence of about 30 per cent of patients with hepatitis C (Okruhlica, 2003). In fact there is a lack of data about hepatitis infections that focus on HBV and HCV among drug users. Most of the data describe specific regions or cities: an overview of the Slovak situation that provides realistic estimations about the number of infected people has not yet been published.

Slovakia is a country with a low prevalence of HIV infection amongst the general population. Since 31 January 2002, there have been 3,333,776 tests for HIV in the country. From these tests, 109 persons were identified as HIV-positive. Of these, 90 were male and 19 female. No case of HIV was identified in the 0–14 age group and no case of vertical transmission (mother-to-child) was identified. The youngest person diagnosed was 18 years old. During the monitoring period, AIDS developed in 32 cases and, of them, 21 people died.

In 2002 ten new cases of HIV infection were found and in two cases AIDS has developed and the two people have died. Among men, the dominant means of

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- 21 The key points of the strategy regarding injecting drug users are: to create policies to increase the awareness of decision makers about the harm caused by drug use and reducing the risks caused by drugs; cooperation with police (training the personnel); elaborating and distributing harm reduction materials; intensifying collaboration between NGOs and the medical services; provide a better understanding of IDUs' practices; and training of personnel about harm reduction methods; support for awareness activities developed in schools regarding drug use within the health education programmes.
- 22 The main characteristics of NPTC 2001–2005 are: health promotion through the optimal use of the medical services, for the prevention of TB-associated risks; the integration of the measures against TB via primary health care; the expansion of the national scale of OMS strategy (DOTS) until 2005; provision of good quality health care services for TB; integration of the activity in primary health care and collaboration with epidemiological network and continuous training of medical personnel.

transmission was through sexual contact with other men); among women, the dominant way of transmission was through heterosexual contact and two cases of transmission via injecting drug use were identified. The expected trends in the spread of HIV/AIDS are, as has been seen in other European countries, through injecting drug use and heterosexual activities.

The incidence of TB in the Slovak Republic has decreased overall since the late 1980s (excluding an increase between 1991–93):

in 1999, the Slovak rate was one of the lowest among the reference countries, but still above the EU rate. National figures suggest that notification rates have not changed in 2000. (European Communities and WHO, 2001)

In comparison to the reference countries, the rate of syphilis was one of the lowest; however, in 1999, the rate was eight times the rate in 1990 and more than five times the EU rate (European Communities and WHO, 2001).

Slovenia is a 'low-level' HIV/AIDS epidemic country with less than one individual per 1,000 inhabitants living with HIV/AIDS. As yet, there is no evidence of a rapid spread of HIV amongst the growing population of injection drug users and their sex partners (WHO, 2000). The Minister of Health in Slovenia stated that he believes that current activities in prevention must be not only sustained but strengthened and that an investment made now will result in a lower HIV/AIDS burden in the future (Keber, 2001). In his report to the President, the Minister of Health stated:

prevention must be the mainstay of the response, while continuing to provide care and support to those already affected. As HIV/AIDS remains concentrated in sub-populations at higher behavioural risk, we should urgently improve coverage with high quality harm reduction interventions for IDUs and develop preventive interventions for commercial sex workers and their clients. (Keber, 2001).

The Slovenian government reported an estimated 13 new cases of HIV/AIDS during 1999, with an estimated 200 adults and children over 15 living with HIV/AIDS at the end of 1999 (WHO, 2000). HIV testing has been available since 1995 and the majority of HIV cases are due to homosexual sex rather than injecting drug use. According to the *National Centre for Treatment of Drug Addiction* the introduction of methadone programmes was timely to slow down the HIV epidemic.

According to the data collected by the Institute for Public Health of the Republic of Slovenia, there were 110 reported cases of HIV in the period from January 1st 1986 (at which time the Institute began to keep records) until March 31st 2003. Several people who developed AIDS have already died; among those who are HIV-positive, eight are intravenous drug users (five males and three females). It is assumed that in Slovenia much less than one person per 1000 is infected (Joze Hren, Counsellor at Government Office for Drugs, 2003).

In Slovenia approximately 60 per cent of all drug users are hepatitis C positive (The National Centre for Treatment of Drug Addiction, 2003). According to drug workers from the Association of Harm Reduction Stigma project (2003):

the public are not well informed about hepatitis C, HIV-AIDS (believing these diseases spread through the air). People are scared of injecting drug use and are afraid for their children. Drug users are seen as bad people, who look ugly, and are rejected socially.

During the period 1998–2002 the prevalence of HCV among IDU involved in the network of Centre for Prevention and Treatment of Drug Addiction (CPTDA) ranged between 20.1 per cent in 1998 and 26.1 per cent in 2002 (Report on the Drug Situation 2003 of the Republic of Slovenia). In 2001, among injecting drug users treated within the network of CPTDA for hepatitis 4.9 per cent were hepatitis B infected and 23.5 per cent were hepatitis C infected (Report on the Drug Situation (2003) of the Republic of Slovenia).

Slovenia appears to have a very low incidence of TB, and both the rate and number of cases have steadily declined since 1995 (WHO Europe Communicable Diseases, 1999–2001).

The preceding discussion provides the context in which to consider the problems that face the prison systems in the countries involved in the research. It is to be expected that if prevalence of HIV, TB and hepatitis are high in the community then the prevalence in prisons will be representative of the community. If the general population require health insurance to access health care in the community then it may well be problematic for prisoners after release to continue treatment started in prison, due to lack of health insurance.

Chapter 4

The prison systems of the ten countries

The prison systems of the ten countries studied have all experienced a period of development since the political changes of 1989–91. This chapter provides a brief description of the structure of each country's prison system including:

- assessment procedures at entry to prison
- visits and home leave
- through care

The assessment at entry to prison is a key time when decisions are made about the treatment that will potentially impact on prisoners general well being and health. It can be argued that the availability of visits, home leave and conjugal visits will reduce the amount of risk behaviour that prisoners will become involved in, for example consensual sex with other prisoners. The long term effectiveness of treatment for problematic drug use or infectious diseases can be increased in situations where good through care is available.

Bulgarian Department for Punishment Execution

The Department for Punishment Execution (Prison Department) is located in the Ministry of Justice. The department is responsible for 12 prisons²³ and a young offenders reformatory. Ten of the twelve prisons are for men only. Nine prisons are for recidivists whilst two are for non-recidivists. There is one women's prison. The age of those in the young offenders reformatory ranges from 14 to 18 years old.

There are also 29 hostels, categorised as follows:

1. closed (for non-recidivists)
2. transitional (that includes recidivists)
3. open hostels.

Transitional hostels are for recidivists, including those who may have long sentences and others with at least six months, but no more than five years, left to serve. Prisoners who meet these criteria, and who have demonstrated positive behaviour, are eligible to go to a transitional hostel. They are selected by a committee consisting of the prison director as the chair, psychologist and social worker, head of the regional court and medical staff.

23 Prisons in Bulgaria have more than one building and type of prison, which may be situated in a different town or village, with a separate staff, but under the overall management of one prison director. They are referred to as hostels or prisons, the terms being used interchangeably. The institutions under the management of one prison director may also have different regimes.

The medical staff are considered to be particularly important in the case of problematic drug using prisoners, assessing the likelihood of a return to drug using after release. The prisoners themselves have to apply for a transfer to a transitional hostel by making a written request. Prisoners at this kind of hostel are able to work (either in the prison or in the local community); they have the reward of home leave, extra family visits, access to education and may also become eligible for early release.

Staff in the sample prisons were generally enthusiastic about the introduction of transitional hostels:

this is a good initiative as it provides normal and humane living conditions for first time offenders. The sentences have become longer so more prisoners end up there [transitional hostel] and have the chance not to re-offend but it is easy to get used to a good thing and some prisoners start to think that the same conditions will prevail after their second offence. This is why the new law says that prisoners should spend one month in the regular prison as a warning [as the conditions are not so good] but then in this month the vulnerable prisoners can also be bullied. I think that we do as much as we can to stop this bullying. (Psychologist, Varna prison, June 2003)

The Bulgarian prison system is modelled on the Belgian system and aims to be in accordance with the European Prison Rules. The prison system is demilitarized apart from the prison guards. The number of staff employed by the Department for Punishment Execution is 4,500 of which 3,000 are guards. The specialist staff working in the prisons (social workers, psychologists, psychiatrists, economists) all hold a master's degree and make up 1,000 of those employed by the prison department.

The Bulgarian prison system has a good normative base with different categories of prison and treatment programmes. These programmes are for adaptation to prison life, re-socialization and a variety of others. There are problems with the state of the prison buildings as they are ageing, having been built circa 1921–30. There are no new prisons being built at this time. As a result, the physical conditions of the prisons are not good (Deputy Director General, Department for Punishment Execution, 2003).

A probation system is currently in the process of being established. There are already probation centres in six towns and their work and experiences were to be evaluated at the end of 2003. The outcomes of the evaluation will be used to inform the implementation of other probation centres. In the future judges will be able to allow prisoners to have early release to attend these centres, under the supervision of the probation service.

Social workers are used extensively in the Bulgarian prison system. There are 12 or 13 social workers in Varna prison and the norm is for one social worker to have responsibility for 60 prisoners. Overcrowding however, has led to this number increasing. The idea for the future is for guards to take over the administrative aspects of the social workers' job leaving social workers free to concentrate on social work issues.

There are four social workers in Lovech prison but this was not considered to be enough by some staff. One social worker felt that their job would be improved if there were more social workers and if there were fewer financial problems:

the budget is so tight and if I can't afford to make a phone call for the prisoners how can I help? New technology would also help to do the job well – to be able to gather and adapt information for the prisoners and to have more opportunities to create the conditions for therapeutic work like a room with a table to sit around. (Social worker, Lovech prison, June 2003)

Assessment period

At entry to prison, each prisoner has an assessment period where a sentence plan is constructed and information is given about the prison rules. The psychologist at Varna Prison considered that the initial assessment unit provided a good period for prisoners to adapt:

...to us the staff and for us to them. Once they are distributed throughout the prison it is difficult to keep track of them. Prisoners who have offended before or who are aggressive are kept on a list to help keep track of them. Once they are allocated to their groups I then work with the social work inspectors. (Psychologist, Varna prison, June 2003)

There are two psychologists at the main prison in Lovech (with one more to be appointed shortly) and they see all the prisoners at reception to the prison. The psychologists prepare a profile of the prisoners and make recommendations for their individual programme. Group work with the prisoners is also scheduled but is sometimes not undertaken due to heavy workload. One of the psychologists in the prison considered the role of the psychologist to be growing as they provide group work for first time prisoners, especially young prisoners, on basic survival skills and how to live in the prison. Some individual counselling is also offered, but with only two psychologists, it is not always possible to provide this for all prisoners.

Visits and home leave

Prisoners can have two visits per month and, with permission from the prison director, the number of visits can be increased. The visits are closed, with a wire mesh separating the prisoner and visitor. Parents and children are allowed to hug. In 1992 this type of closed visit was removed but this was considered to be a mistake due to the opportunity open visits provided for smuggling. In the transitional or open prisons there are table visits and the prisoners can sometimes be outside in the garden. There are no guards present during visits.

The prison director at Lovech prison felt that as a lot of the prisoners were from Varna, relatives would not be able to make regular visits due to the distance involved. They are trying to arrange for prisoners be in prison in their home regions.

The prisoners in the focus group from Troyan prison (part of Lovech group of prisons) were not happy with the location because:

it feels hard to be here as we all came from Varna and it makes it difficult for us to see our families. I haven't had a visit for four years; I don't really know why, maybe it is because of the distance. (Prisoner focus group, Troyan prison, June 2003)

Through care

In Bulgaria community social workers used to link with prisons but now it is the local government's mandatory responsibility to work with prisoners at release from prison. The prison notifies social work services three months prior to the prisoner's release and they provide basic social assistance. The prisoner's family is visited to ascertain if they will take the prisoner back home. (Representative from the Social Work Department in Varna, June 2003). Currently however, there is not a well-established social work system in Bulgaria.

Lovech prison has links with an NGO that, for the first month after release, assists prisoners in obtaining new ID papers, provides information about employment, helps them to continue their education and to make links with their relatives. The prison does not have official links with any NGOs that provide services for drug users, to which they could refer prisoners at the time of their release from prison. The prison director hopes that as the new probation service develops this will provide through care for prisoners.

Prisoners at Varna are directed to the local government committee office, where they can obtain a range of information. This includes written information about the local government committee office given at the time of release. The Director of Varna prison has regular meetings with local and regional government officials to ensure good co-operation with the prison. A range of different institutions is provided with information about the prisoner who is about to be released, but this needs to be co-ordinated and the probation centre will do this in the future. There is also a local company that receives a subsidy from the state for employing ex-prisoners..

Czech Republic Prison Service

The General Directorate of the Prison Service is under the responsibility of the Ministry of Justice. There are 35 prisons in the Czech Republic and three prison hospitals. The number of prisoners at the time of the visit was 16974 (13/08/03).

A new Probation and Mediation Service has been established in the Czech Republic and this is considered by the General Directorate of the Prison Service to be a powerful tool in:

- the rehabilitation and resettlement of offenders;
- prevention of re-offending; and
- helping to reduce prison overcrowding with all positive consequences of these three goals. (Meclová, 2002)

The probation service is also expected to be a key resource in the management of problematic drug users in the provision of throughcare.

Assessment period

According to the Prison Act, prisoners with a sentence of longer than three months must have a treatment programme. The treatment is based on a report prepared by a team comprising an educator, psychologist and pedagogue:

upon arrival prisoners in the women's section at Opava prison are seen by the psychologist, educator and pedagogue who make up a profile of the prisoner and prepare a programme. Prisoners are then broken into groups according to their behavioural profile, who they are likely to get on with, and so on. All prisoners arriving at the prison go through a 'specialised induction department' that informs them about prison routines, regulations, and specialist treatment units. (Specialist Staff, Opava prison, women's section, 2003)

Estonian Department of Prisons

The Department of Prisons is located in the Ministry of Justice and was created in 1999. At the moment there are eight closed prisons and one open prison institution in Estonia.

The Imprisonment Act (RT 1 2000, 58, 376) emphasises a commitment to the 're-socialisation' of prisoners. All Estonian prisons provide psychological support and there are currently 21 psychologists working in prisons. Each prison has a social work department and a medical department. Health care for prisoners is a part of the National Health Care System paid from the state through the Ministry of Justice.

Assessment period

At entry to prison each prisoner has an assessment period where their sentence plan is constructed and they are informed about the prison rules.

The reception phase consists of two stages. The first stage begins with the arrival of the prisoners into the prison and their placement into the reception department of the prison. Within 48 hours of arrival at the prison, the director of the prison (or a person authorised by him) will meet the new prisoners to inform them about their rights and obligations. The second stage is the formulation of the prisoners' individual sentence plan. The specialists involved in the sentence plan are the social worker, the person responsible for education and employment, the medical doctor and some of the heads of the other departments. The individual sentence plan will be reviewed, as a rule, once a year. In the case of young prisoners, it will be reviewed every six months, and if necessary, amendments will be made. Once the sentence plan is decided, the prisoner is placed in the appropriate section of the prison and, in some cases, moved to an open prison. Prisoners will not spend more than three months in the reception section of the prison.

At reception to Viljandi juvenile prison, the prisoners are kept separate from the rest of the prison for a two-week assessment period. During this time, they are

informed about the prison rules. Throughout the assessment period the regime is quite strict; the prisoners have to wear the prison uniform and are subject to other restrictions. The regime is gradually relaxed however and prisoners can have more possessions and wear their own clothes. During the assessment period, the prison social worker meets the prisoners frequently and co-ordinates the sentence plan. Preparation of the sentence plans involves a range of specialists who, with the prisoners, set the objectives. The psychologist interviews all the prisoners during the assessment period as does the pedagogue who tests their reading, memory and mathematical skills in order to decide the appropriate grade of school that they require. Some staff felt that not all prisons complete the sentence plan correctly, especially in the very large prisons.

In the new Tartu prison, the first group of prisoners arrived in the prison at the same time so they were seen in a rota. The reception process is now normalised. The social workers deal with new arrivals and the psychologist sees the prisoners later, if they make an application to see her, together with those who need sentence plans [if they don't have one from the previous prison]. All prisoners are required to have a sentence plan and this may already have been formulated.

Tartu prison does not have a two-week assessment period. Instead, during the first day in the prison, prisoners are informed of the rules and then given the name of the contact person (see below for discussion of the role of this person) on their section. This contact person is responsible for informing prisoners about rules and also acts as a link between the prisoner and the departments within the prison. Additionally, the contact person monitors how prisoners comply and progress with their sentence plan.

The sentence planning here and in other prisons are different, but the basic information comes from the same group of specialists. The contact person is involved with sentenced prisoners only, with a case load of approximately forty at any one time. The system has some elements from the Swedish structure that utilises one contact person per five prisoners. For pre-trial prisoners the social worker and psychologist prepare the sentence plan. The prisoners in the focus group (Prisoner focus group, May 2003) felt that:

the system [of contact person] is ok but some contact workers are better than others. In reality you have no choice but to use them if you want to see a social worker or psychologist.

Each section in the prison has a social worker and psychologist allocated to it. The pedagogue is an educational adviser responsible for skills assessment and determining what class a prisoner should be allocated to, or what vocational training might be appropriate. There are employment specialists in the prison in another department who are also linked with sentence planning.

Visits and home leave

After completing 12 months of their sentence, prisoners are entitled to 21 days of home leave. However, they are not allowed to take the 21 days at one time and usually have home leave for seven day periods. Prisoners can also have long-term visits, and a minimum of one per six months is allowed. The long-term

visits allow prisoners to have their family in a special room within the prison for three days, with the proviso that the family pay for the heating and electricity in the room. These visits are only for sentenced prisoners who are married, have lived together with the visitor for two years, or who have had children with the visitor. The visits can start at any part of the prisoner's sentence, at the discretion of the prison management.

Through care

At the Viljandi prison in Estonia there is not any through care for the prisoners after they are released from the drug free unit. This lack of through care for drug using prisoners is considered to be a problem. There is a real need for support for the prisoners in the community to help them to keep drug free.

However, the majority of the juveniles who get parole are placed under the care of the probation service and the courts, which provide limited help. There is one volunteer from the Estonian Pentecostal church who used to be a drug user who now talks to the juveniles at Viljandi prison about his experiences of drug use and how he found God. He finds that the prison is very welcoming and receives good co-operation from other staff. The volunteer tries to offer help and direct the juveniles to the churches and the Estonian Association of Churches that has established a rehabilitation centre (for adults who have been in prison for a long time).

Hungarian Prison Department

The Hungarian Prison Department is located in the Ministry of Justice. The prison department has 33 establishments including two hospitals (World Prison Brief, 9/5/02) with an official capacity for 11,310 prisoners. The current prison population is 16,700 (20/11/03) giving an occupancy level of 147.7 per cent (World Prison Brief, 20/11/03).

The length of pre-trial detention is variable with the average time being three to seven months (2003):

although nearly 10 per cent of detainees were held for periods ranging from 8 to 12 months. Foreigners are usually held until their trial since they are considered likely to flee the country. (Drug Law and Health Policy Resource Network, 2002)

Assessment period, visits and home leave

All prisons have an assessment unit where a range of specialist staff, including psychologists, meet the new prisoners. The assessment period lasts for a maximum of 30 days although the prison director can extend it for a further 30 days. In practice however, the assessment period is usually less than 30 days duration (Prison Service Department, 2003).

Conjugal visits are currently not available for prisoners. The Prison Department is waiting for a new act that will make such visits possible and this is likely to be ratified in 2005. It is necessary for the prison department to prepare appropriate rooms for these visits, as one member of staff commented:

Suitable facilities for family visits [conjugal] have not been done as yet in the prison. Prisoners will be eligible for a family visit as a reward for good behaviour. If the prison provides 10 rooms for family visits and if there are 800 prisoners it won't be possible for all prisoners to have one! The time for these visits could be from 4 hours to 24 hours so approximately 16 prisoners could have such a visit per day. (Specialist Staff, Budapest prison 2003)

Prisoners (dependent on the crime committed) can also have home leave for 24 or 48 hours, again as a reward for good behaviour. Prisoners from the focus group felt that it was much harder now to meet the criteria to be eligible for home visits. They also considered the visits to be really important:

I spent six years in the strictest regime and I am not sure what I will do when I get out as I am not used to life outside; so it is really important to be able to keep contact with people outside. If a prisoner behaves well, they should be allowed to go on home visits and to be treated humanely. Not everyone should be treated as the most dangerous criminal in the world, because many of us are not, and people [prisoners] should be helped to be better and not treated in a way to make them worse (Prisoner focus group, Budapest prison 2003).

Through care

At Baracska National prison in Hungary the educators are informed about prisoners due to be released. They then talk with prisoners to ascertain if they have a home and job to go to upon release. The educator will contact the Local Authority if a prisoner is homeless.

Latvian Prison Administration

The Latvian prison administration has been located in the Ministry of Justice since January 2000. The move to the Ministry of Justice is part of the demilitarising of prisons following the end of Soviet control, with the aim to create more humane conditions for prisoners. Another aspect of demilitarisation is:

overcoming the formal, very distant relationship between prison staff and prisoners, establishing communicative relations and creating what we call inner or dynamic security in prisons. Other initiatives taken by us to demilitarise prisons have focused on the setting up of trade unions for state officials and civilian prison staff, so that prisons may be regarded as fully civilian institutions. (Director General of Prison Administration, 2002)

A key component in reforming the Latvian prison administration is to increase the professionalism of prison staff. There are 2,350 people working within the prison administration and over 95 per cent of them are skilled workers (Director General of Prison Administration, 2003). As the first step in professionalising prison staff, all new recruits undergo three months of basic training at the staff-training centre.

Latvia's prison system consists of a staff training centre and fifteen prisons, of which three are investigative pre-trial detention centres, and there are also pre-trial units in five other prisons. The prison system is built around and based on:

the principles of the traditional English system of progressively executing/serving a custodial sentence with a differentiated approach to the different categories of prisoners, corresponding to the security classification of establishments, an individual approach to each prisoner and stimulation of their behaviour while they serve their sentence. (Director General, 2002)

There are three types of prison regime: closed, semi-closed and open. Within these types, there are three levels of regime. The level and type of prison can be changed during the prisoner's sentence.

The Latvian prison administration considers that the rejection of the Soviet style camp prisons has led to:

a more civilised and secure form of imprisonment and secured a sharp drop in the number of offences and breaches of regulations. It would be difficult to achieve such a positive breakthrough with legislative and organisational measures alone, were it not for substantial investment also in the rebuilding of prisons. (Director General, 2002))

There has been a substantial investment in the rebuilding of prisons and the improvement of prisoners' everyday conditions since 1995 whereby:

between three and four prisons are under reconstruction each year (or more precisely certain blocks within those prisons, since prisoners are not moved between prisons). Large accommodation units are being converted into smaller units of three types: a) for the detention of 1–4 prisoners; b) for the detention of 4–8 prisoners, c) for the detention of 8–18 prisoners (as of 1 November 2002, 4,800 of a total of 8,437 prisoners were being held in such conditions). It is premature as of yet to talk of cells for 1–2 prisoners. (Director General, 2002)

As part of its aim to create more humane conditions for prisoners, the Latvian prison administration has identified psychologists as key specialists that are needed to work with prisoners. At present, the psychologists who work within the prisons do not have an official status:

there are four psychologists in four prisons but they are officially working in other positions. (Prison Administration, 2003)

Although there are no social workers amongst the staff of Latvia's prisons, there are social rehabilitation staff who are graduates. They are usually heads of the

sections (units) within the prison and are responsible for between fifty to one hundred prisoners. They are also responsible for through care (Prison Administration, 2003).

Currently, 43 per cent of all prisoners are pre-trial detainees and those awaiting the result of an appeal against sentence. Since prisoners have the right to make more than one appeal against their sentences, the process of sentencing is very time-consuming. According to the new legislation, juveniles should be pre-trial for no more than six months and adults eighteen months. The regional courts have problems dealing with the number of cases, especially in Riga where 50 per cent of the population live. However, for all crimes, the court process often takes a long time before the sentence is finally confirmed.

Visits and home leave

Prisoners in Latvia are allowed both short and long visits. Long visits (known as 24-hour visits) are for a spouse or partner (if living together before prison) or can be for family members. The legal procedure for long visits (according to prison rules) requires prisoners to provide a list of who they want to visit them. The number of visits that prisoners are allowed is calculated according to their sentences, their behaviour and what regime they are on. Prisoners in the focus group were mostly positive about these visits:

the long visits are a very positive thing but you have to be married and not just have a long-term girlfriend but your visitor has to get a syphilis clearance paper from the doctor. (Prisoner focus group, Pārlielupes prison, 2003)

In some situations it is possible for a prisoner to have a long visit once per month. In Pārlielupes prison, the building for long visits had rooms and kitchen facilities. Previously, condoms were available in the long visits section.

Through care

In Latvia each prison has a special social worker responsible for preparing the prisoner prior to release – this is mainly by the provision of information on where to go at the time of release for assistance. Some volunteers come into the prison to speak to prisoners about various issues related to life out of prison. However, there is only minimum help available in the community for ex-prisoners. There are limited social services available in the community and this makes it difficult for the prison to arrange through care. In theory, local governments are obliged by law to provide housing for ex-prisoners but in practice housing is one of the main problems for ex-offenders. Women ex-offenders with children may risk their parental rights if they are homeless after release.

Some prisons collaborate with external agencies, religious organisations and care homes for old people to find housing for prisoners after release. Currently, there are no programmes to help ex-prisoners with employment after release. Prisoners who gain work experience in prison have a much better chance of finding employment than those who do not. Employers in Latvia, however, are still very reluctant to employ ex-prisoners.

Lithuanian Correctional Affairs Department

In the year 2000, the Correctional Affairs Department was transferred from the Ministry of the Interior to the jurisdiction of the Ministry of Justice. There are thirteen imprisonment institutions in Lithuania and a special hospital all of which are supervised by the Correctional Affairs Department.

The reform of the Lithuanian Prison System has included major changes to the classification of prisoners:

with the introduction of numerous incentives, vocational training and education. The classification of inmates should include the following criteria: the age and the sex of an inmate, the nature of the committed crime as well as his/her urge for education, maintenance of social relations and improved behaviour. The list of incentives for the persons sentenced to imprisonment has increased – it includes short-term leave from correction houses and conditional release. Vocational training of prisoners is orientated to the perspective of finding a job after release. Both vocational training and education is becoming strictly voluntary as it is a central determinant in the process of evaluation of a person's readiness to reform. (Kugis, Director General of Correctional Affairs Department, 2003)

There is one institution in Lithuania for young offenders between the ages of 14 to 18 years. Kaunas Juvenile pre-trial prison and Correction House prisoners are divided in to two groups: the ordinary regime group and the mild regime group.

Since September 2003 all Lithuanian prisons are staffed by trained prison staff and no longer by military staff. This is considered to have led to better communication in the prisons where all staff now belong to the Correctional Affairs Department (Director General, Correctional Affairs Department 2003).

Assessment period

The successful implementation of sentence planning is variable as it depends both on the quality of staff and the number of prisoners that each member of staff is responsible for in each individual prison (Director General, Correctional Affairs Department 2003).

The assessment period for new prisoners involves seven to fourteen days. At Alytus Correction House, each prisoner at reception spends one week on a special section in a cell with two or three other prisoners. During this period, health care staff, a psychologist and social workers assess the prisoners. At Kaunas Juvenile pre-trial prison and Correction House there is a fourteen-day assessment period when they are assessed by the psychologist, educator and medical staff. The psychologist in the prison prepares an assessment form for each of the new prisoners:

The assessment form records the prisoners' previous suicide attempts, their family history, previous use of drugs and alcohol. I don't ask the boys about their crime as it is important that I gain their confidence. I use some short

evaluation tests and the results of these are confidential. (Psychologist, Kaunas Juvenile pre-trial prison and Correction House 2003)

The educators' main role during the assessment period is to read the prisoners' records and help them to adapt to prison life. They also explain the opportunities available in the prison and communicate with parents at visits (it is obligatory for educators to talk to parents and the parents usually appreciate this opportunity). The educators also look after hygiene, clothing for prisoners and organise prisoners' free time.

Visits and home leave

Prisoners, dependent on their behaviour, can have four long-term visits (up to two days in length) and this number can be increased as a reward for good behaviour. At Kaunas Juvenile pre-trial prison and Correction House, long visits (for family members) have been possible since May 2003. However, before the visits can take place the prison needs to prepare rooms. Funding has been allocated for this purpose and they hope to receive the funds in 2004.

Through care

Continuity of treatment for prisoners in Lithuania is problematic as often prisoners have no health insurance and no job. This results in a period when they have no access to health care while they are looking for work. The Director General would like a scheme similar to those in other countries, where prisoners are insured for the first year after release. This type of insurance scheme for prisoners after release has been discussed and agreed in parliament and the legal framework is now being prepared (Director General, Correctional Affairs Department 2003).

At Kaunas Juvenile pre-trial prison and Correction House there is a pre-release programme involving the psychologist and educators. The programme involves finding housing for prisoners, arranging the necessary documentation and providing them with information about free help lines and other useful organisations.

The pre-release course at Alytus Correction House during the last six months of the sentence is voluntary so not all prisoners attend it. As one member of staff commented:

There is a lot of time needed to convince prisoners that these programmes will help them. The prisoners often feel rejected by society and are negative about any help. Written information could be provided if the prisoner wants it but they often don't. The programme gives information about dealing with housing problems, information about society and the State. If prisoners have drug problems they are given information regarding drug centres that can help. Prisoners become dependent after years in prison and want everything done for them and yet they don't come to the pre-release programme. (Staff, Alytus Correction House 2003)

Polish Prison Department

The Central Board of the Prison Department in Poland is a division of the Ministry of Justice and is directly responsible to the Minister of Justice. There are fifteen regional inspectorates of the Central Board of the Prison Department, which are responsible to the Central Board, and these oversee a total of 86 prisons, 70 pre-trial prisons, 32 external units, 14 prison hospitals and two facilities for mothers with small children. In addition, there are fifteen staff training centres for the Central Board of the Prison Department.

The majority of Poland's prisons are old establishments with concomitant structural problems. This is a factor in addressing the health needs of prisoners. Ninety-six (64.5 per cent) of Poland's prisons were constructed before 1914. Eight of the prisons are historical monuments and were built between the thirteenth and fourteenth centuries. Fifteen were built between 1918 and 1939 and six are based on converted prisoner of war camps from the Second World War. Only 36 units (23.3 per cent) were built after the Second World War. Despite growth in the size of the population at large, and a concurrent rise in the country's prison population, there are now less than half the number of correctional facilities (156) that there were in 1938 (344).

According to the national prison administration²⁴ the prison population in Poland is 80,693 (at 1.9.2003), including pre-trial detainees/remand prisoners. The number of prisoners has risen markedly in recent years. During the 1990s, figures were stable at about 65,000, but in 2000–02, this rose from 70,000 to current levels.

Home leave

In the Polish prison system home leave is an important part of the preparation for release:

So is the provision in the Penal Executive Code enabling certain prisoners to leave the prison in the last months before release in order to find employment and accommodation. Case-managers work with prisoners in a variety of ways, and also involve prisoners' families in making preparations for them to be as well prepared as possible for the circumstances that they are most likely to face on their return to normal life outside. (Walmsley, 2003:409)

Through care

In every prison in Poland case managers are responsible for issues relating to the situation that prisoners will face after release from prison. In 2003, 3000 prisoners took part in training for 'active work search'. This training was organised by an NGO called Bureau of Social Initiatives that was financed by the PHARE programme²⁵. During the project, staff have been trained and labour clubs established in many prisons, ensuring that the labour project is able to continue.

24 See World Prison Brief (www.prisonstudies.org), from which table 1 is taken.

Romanian General Directorate of Penitentiaries

The Romanian General Directorate of Penitentiaries is part of the Ministry of Justice. There are 43 prison institutions including 34 prisons, six prison hospitals and three centres for young offenders. The prison population was 46,789 in June 2003 (General Directorate of Penitentiaries, Internet Site: www.anp.ro).

A key issue facing the Romanian General Directorate of Penitentiaries is the demilitarisation of prison staff. The vast majority (92 per cent) of the 13,256 of prison staff are military personnel and only 8 per cent are civilians. The need for the demilitarisation of the Romanian General Directorate of Penitentiaries arises from more than half a century of totalitarian government and for the following reasons:

- it will place the onus squarely on individual responsibility in the performance of staff's tasks and duties, within the framework of regulations governing the special civil service status of prison staff;
- it will bring the Romanian General Directorate of Penitentiaries more into line with European standards and practice;
- it will create an environment more conducive to frank and sincere communication among staff and between staff and detainees;
- it will bring about a change from a military-type mentality to a less rigid attitude where interpersonal relations are based on respect, discipline and professional responsibility (Director General, 2002).

A law has been drafted and submitted to parliament for approval that will enable the demilitarisation of the General Directorate of Penitentiaries and this is expected to take place in November, 2004.

Assessment period, visits and home leave

The assessment period upon arrival to prison lasts for twenty-one days. Within this period, prisoners are seen by a psychologist and educators (for social and legal issues). Each prisoner undergoes social and psychiatric assessment and is introduced to the common programmes provided in the prison. At the end of this assessment, each prisoner will have an individually tailored programme for the whole term of imprisonment.

At Rahova prison there are five psychologists employed by the prison who see all new prisoners. Not all prisoners who come to Rahova prison undergo this assessment period as most prisoners (apart from women and juveniles) will have come from other prisons and been assessed there. All prisoners at Târgșor prison for women have a twenty-one day assessment period.

The type of visit allowed to prisoners depends on the crime committed. Former drug-dependents, drug dealers and dangerous prisoners have closed visits as set by the law. At Rahova prison, other groups of prisoners receive table visits but

25 The Phare programme is one of the three pre-accession instruments financed by the European Union to assist the applicant countries of central and eastern Europe in their preparations for joining the European Union.

physical contact between visitors and prisoners is not allowed according to the law. However, prisoners are allowed physical contact at the discretion of the prison director.

According to legislation, conjugal visits are not available to prisoners. If a prisoner gets married then it is possible for the prison director to allow a 48 hour visit in the prison if there is suitable space available. The director of the prison was in favour of conjugal visits once per month because 'if this type of visit is not available then some (male) prisoners will have sex in the prison with men' (Prison Director, Rahova prison 2004). At Rahova however, there is currently no suitable space available.

Home leave is possible for Romanian prisoners. At Rahova, home leave is granted usually at holiday periods and all prisoners who have been given home leave have returned to the prison afterwards. The prison director would like to see more home leave near to the end of prisoners' sentences as part of a rehabilitation programme. There are two new laws (23/1962 Penal Execution Law) under consideration that impact on prisoner rehabilitation. These would allow more home leave at the end of the sentence and enable differentiated regimes to be implemented. One key problem identified by the prison director was that it can take up to a year for the courts to approve the application of suitable prisoners for parole²⁶.

Through care

There is no formal pre-release programme for prisoners in Romania. However, prisoners go to the reintegration department in the prison where they are given information about work availability in the area where they are settling after release. The prison liaises with the social workers at the relevant Town Hall. Prisoners are not provided with help to find housing.

At Târgșor prison the psychologist works with prisoners' families throughout the sentence but focuses more on the pre-release period. In cases where the prisoner is homeless, the local community becomes more involved.

Slovakian General Directorate of the Corps of Prison and Court Guard

The Prison Department is located in the Ministry of Justice. Prison staff are members of the prison and police guards and they are organised under the same Act that governs the police. The specialist staff, such as psychologists and educators, are also part of this system. The intention in the near future is to make 27 per cent of the prison staff civilian employees. There is expected to be a salary differential between the two groups of staff.

26 The application of suitable prisoners for parole depends on the period of time that the medical expertise takes within the Ministry of Health.

There are 18 prisons in Slovakia that include one prison hospital, one prison for sentenced women, one prison for juveniles (for prisoners between 15 to 18 years). The prisons are not considered by the Prison Department to be overcrowded apart from pre-trial prisons where there are 2905 prisoners and an official capacity for 2658 (8/01/04 General Directorate of the Corps of Prison and Court Guard).

Sentenced prisoners are divided into three levels:

- 1st Correctional Group – This is the lowest security group and contains the open prisons [here prisoners are not guarded and they can go out to work];
- 2nd Correctional Group – medium security group;
- 3rd Correctional group – This is the strictest security group that includes those serving life sentences.

Within these externally set groups there are four internally set regimes labelled A to D, with D being applied to the most difficult group of prisoners.

Assessment period, visits and home leave

The initial assessment programme for prisoners takes place in one prison in each region. Over a period of three weeks, new prisoners undergo a variety of tests and are subsequently dispersed among the other prisons.

At Sučany–Martin prison prisoners are seen by a variety of prison staff over four days. At the end of this period prisoners are told where their cell is and what work is available to them. In addition the pedagogue, educator and social worker will develop a programme for the prisoner.

Prisoners in open and semi liberty are allowed home leave of 48 hours or 24 hours with their families. In addition, as a reward, prisoners can have up to five days home leave. There are no conjugal visits available in Slovakian prisons.

At Sučany–Martin juvenile prison the prisoners are allowed weekly visits. In addition, if the parents happen to be in the location of the prison, they will be allowed a half hour visit with their son. Most of the juveniles receive visits from their parents but this depends on the distance from their homes. The juveniles can also have up to five days home leave as a reward for good behaviour.

Through care

In Slovakia the prison service works with NGOs that offer education and training courses and re-socialisation programmes. There are thirteen church groups who come into the prisons. There are also priests, who work in the prisons as part of the prison corps, and who are paid by the Prison Department.

At Sučany–Martin prison the educators are in contact with juvenile prisoners' parents and also with the re-education facilities in the community. After release from prison, some of the prisoners have to attend these residential centres and the prison social worker provides the link. The prison does not have a pre-release course. As the average stay of the juveniles is approximately seven months, there is not enough time for a formal programme.

Slovenian Prison Administration

The national prison administration was established in 1995 and operates within the Ministry of Justice of the Republic of Slovenia. There are thirteen penal institutions in Slovenia:

six of these are the main prisons (three of them central prisons – for those with sentences over 18 months – and three regional prisons), and another six are administered as separate (‘dislocated’) departments of the three regional prisons. The other institution is the correctional home for juveniles. (Walmsley, 2003:486)

Juvenile prisoners are those aged 14 to 18 years and those under 16 years old go to the Correctional Home.

There were a total of approximately 1150 prisoners in Slovenia in 2003 (Director General, Prison Administration 2003). The number of prisoners has stabilised in the last 3 years. Slovenia has a low number of pre-trial prisoners:

pre-trial detainees normally spend four hours a day out of their cell and as many as 15 per cent of them are able to undertake paid work. No other country in central and eastern Europe is known to equal these achievements. It should be noted however that the CPT recommends that they should spend a minimum of eight hours outside their cells, engaged in purposeful activities of a varied nature. (Walmsley 2003:486)

Based on international recommendations and the findings of Slovenian experts, the national prison administration adopted common principles for the determination of prison capacities in 1997, with the size of single cells being 9 square meters and the size of group cells being 7 square meters per prisoner. These standards, prescribed by the Minister of Justice in 2000 by the Prison Sentence Enforcement Rules (Ur. I. RS, 102/2000, Article 27), are applicable to all prisoners. This aspect of Slovenian legislation is harmonized with Council of Europe recommendations.

Assessment period, visits and home leave

Each prison has an ‘expert group’ who prepare individual programmes for all prisoners within the first month after reception to the prison²⁷. The pedagogue, educator and psychologist prepare the programme. In addition the social worker prepares a report about the family circumstances of each prisoner. The aim of these programmes is to provide educational opportunities (provided in the prison and outside of the prison), work and employment, full-time activity, a strategy

27 The programme is prepared on the basis of the introductory talk with the prisoner, his/her file and what the prisoner says and wants. The programme is thus an arrangement between the prisoner and the institution and is sealed with a contract that the prisoner signs. Every three months the prisoner’s programme and development are monitored and examined by the expert team, including the prisoner, and signed by the prisoner. The prisoner cooperates on a voluntary basis and he/she must give consent to join in any programme. After the monitoring and evaluation, if all is going well, the prisoner receives privileges, as set by the law. If the prisoner breaks the rules, his/her privileges are removed.

for drugs and alcohol prevention, work with prisoners' families, and pre-release preparation. Slovenian prisons provide facilities for intimate visits.

Prison leave is a privilege that may be granted, like other privileges, to prisoners by the prison director provided they are actively cooperating in the treatment process, are making an effort, are successful in their work and respect the prison's rules. Prison leave can be granted up to four times in one month and may be up to 48 hours in duration (Director General, Prison Administration 2003).

At Ljubljana prison if a prisoner is granted prison leave, it is usually to go unaccompanied to the university or school. If the prisoner is unable to go alone, they will be accompanied to their education courses by a guard (in civilian clothes). Pre-trial prisoners may also be granted permission to continue their education outside, but only with the consent of the court (Prison Director, Ljubljana prison 2003).

Through care

In Slovenia at the time of a prisoner's release the national prison administration cooperates with social care centres, employment agencies, administrative authorities for housing and public institutions for healthcare and education. The Administration also co-operates with charities, for example Caritas, the Red Cross, other non-governmental organizations, self-help organizations and other civil society organizations (Director General, National Prison Administration 2003). Contact is made with the Social Work centre prior to a prisoner's release. There is also a link established with therapeutic centres that are available to prisoners after release. The information is given to prisoners but the onus is placed upon the individual to take the initiative and follow up the contacts themselves.

At Ljubljana prison the director explained that the prison has established close connections with outside agencies such as social work departments, the employment office, and the university (students from the university visit the prison for work or internships). A prisoner from the focus group thought that the preparation for release was minimal:

Nothing changes until the last day you're here. They [prison staff] have the same attitude, no matter how long you've been here, no matter when you're going out. There is no preparation – they just kick you out and that's it. You're not their problem anymore. (Prisoner focus group, Ljubljana prison 2003)

Chapter 5

Key issues for the prison administrations of the ten countries

The ten countries face a range of similar problems and issues. The common problem facing the prison administrations of these countries, that in some instances reflects the situation in the wider community, is that there are increasingly high numbers of problematic drug users in prisons. Some of these continue to use, and in some cases inject, drugs while in prison. Furthermore, prisons are often overcrowded and in need of refurbishment. There is also a high incidence of hepatitis and, in some of the countries, a high incidence of HIV amongst prisoners. Prison provides an opportunity for prisoners to address their educational needs and to increase their social and occupational skills. The ability to work or to be engaged in meaningful activities while in prison can reduce boredom and discourage prisoners to continue (or start) to use drugs in prison²⁸. The key issues that will be discussed in this chapter are:

- overcrowding
- budget constraints
- problematic drug users in prison
- availability of drugs in prison
- communicable diseases
- availability of activities and education
- sex, prisoner hierarchy and bullying
- suicide and self-harm.

Overcrowding

The majority of the ten countries identified overcrowding as a key problem. All the prisons shared the same problems associated with overcrowding (high prisoner to staff ratio, decreasing opportunities for prisoners to work and so on). However, not all of the sample prisons were considered to be overcrowded at the time of the visit.

In Bulgaria the last three CPT reports have highlighted the problems caused by overcrowding. Under a new law, after having served half of the sentence (with no more than 5 years remaining to serve) a prisoner can go to a transitional hostel that has a less restricted regime.

28 For a comprehensive account of the regulations governing work and activities in prisons see Walmsley, 2003.

Overcrowding in the Czech Republic was not considered to be a problem at Příbram Prison. However, at Opava prison, the sections for sentenced prisoners were overcrowded with three prisoners in cells designated for two.

In Estonia the prison population is decreasing slightly due to the new penal code and the minimum age of imprisonment rising from 13 years to 14 years of age. The accompanying release of 13 year-olds from prison has served to reduce the prison population. There are also more possibilities for pre-release for prisoners and some activities (for example, personal drug use) have been decriminalised.

In Hungary the condition of the prison buildings and the slow pace of refurbishment were identified as particular problems. In some instances, the Prison Department considered conditions unsuitable for prisoners. Like many others, the Hungarian prison system suffers from overcrowding and staff shortages. There is concern at the Prison Department that changes to the law in force from 1 January 2005, which will allow police detention for thirty days only, will substantially add to prison overcrowding.

The educators in one of the sample prisons are, on average, responsible for as many as ninety prisoners because of overcrowding and this has impacted on their work. A concomitant increase in the amount of drugs in prisons and greater administrative pressures, reduce time available for the personal approach that the prisoners need. (Prison staff, Baracska National prison 2003)

Overcrowding in the Latvian prison system was considered to be much less of a problem than it was during the Soviet period, although conditions in the prison system are still not considered to be ideal (Prison Administration, 2003).

In Ilguciema prison the majority of staff considered overcrowding to be a problem. Although the official capacity at Ilguciema is 382, there were 475 prisoners at the time of the visit (22/07/03), which is 124 per cent overcrowding. As the deputy director said 'the prison buildings are very old and overcrowded. I would like the prisoners to have more space'. The lack of available space in the prison affects some of the staff working with the prisoners. For example, a member of the specialist staff complained about the lack of space available for confidential meetings with prisoners.

After the amnesty for prisoners in mid-2000, the total Lithuanian prison population decreased from 14,412 in January 2000 to 10,750 (of whom 1,766 were pre-trial detainees) in September 2001. However, overcrowding remains a problem (Commission of the European Communities, 2001). The prison population is decreasing due to the new criminal codes introduced in May 2003 that provide for alternatives to custody and make it possible for prisoners to have early release from their sentence (Director General, Correctional Affairs Department 2003). One member of staff at Alytus Correction House commented that although the prison was not overcrowded the rooms for prisoners were large and in need of refurbishment.

The prison population of Poland was 80,000 in August 2001:

the number in the penal institutions at the beginning of 2001 was 104.3 per cent of the total capacity. Two thirds of the institutions (53 of the 70 pre-trial

prisons and 51 of the 86 institutions for sentenced prisoners) were overcrowded, with the two largest pre-trial prisons more than 20 per cent overcrowded. By the end of August the occupancy level had risen to more than 117 per cent. (Walmsley, 2003:399)

Overcrowding was identified by staff at the General Directorate of Penitentiaries in Romania as a problem that impacts on the spread of TB and sexually transmitted infections. In addition, the prison architecture, where prisoners are housed in large rooms of fifty or sixty prisoners, impacts on hygiene standards.

In Slovakia, in order to address overcrowding in the prison system, three medium security prisons have been converted into pre-trial prisons and in July 2004 a new wing for 650 prisoners will be opened near Bratislava. A new prison for women, with a capacity of approximately 200, has also been built. The prison department believes that there is a need for another prison in Bratislava to increase the amount of space available per prisoner.

At the time of research, 35 per cent of Slovenian prisons were overcrowded, including the two sample prisons, Dob and Ljubljana. A new prison is being built, which will be the first in the last forty years. Overcrowding was also seen as having an impact on the quality of services that specialist staff can provide:

psychologists working in prison face a range of difficulties, in part caused by overcrowding where there are too many new cases to be managed effectively. This is made worse due to a lack of expertise of young psychologists newly appointed to work in prisons. (Head of Psychology, Prison Administration 2003)

Budget constraints

In common with most prison systems, the allocated budget was raised as an issue by most of the ten countries.

In Bulgaria the Deputy Director General of the Department for Punishment Execution was not keen to discuss this area, but did volunteer that the budget is not large for the prison service. Staff at Varna prison indicated that financial constraints determined how they were able to treat prisoners and the extent to which they could improve professional practice. One member of staff commented that although yearly courses are provided by the Department for Punishment Execution, more could be achieved:

if there were enough funds like there were when I first started when we used to have two meetings nationally to share experiences. This was a very useful staff development exercise. Now someone comes up with an idea and it is circulated as a fax and then this becomes practice and there is no money to bring the implementers together to share experiences about how it works in practice. This results in an uneven implementation across the different prisons. We can't even talk to each other on the telephone as staff can't even make outside calls. (Specialist staff, Varna prison, June 2003).

The director of Přebram prison in the Czech Republic noted that financial issues were a problem, particularly in respect of refurbishment and reconstruction work required due to the age of the institution. The specialized drug treatment unit in Opava prison receives more financial support than the rest of the prison. The initiative to create the unit arose from societal concerns with the increase of illegal drug use and trafficking since 1991.

In Estonia resources were cited as a major problem especially for the maintenance of the juvenile prison. There was also uncertainty in the prison about its long-term future caused by the decreasing investment in refurbishment. The Health Care Adviser from the Estonian Prison Department considered the budget for HIV for 2003 to be good. In addition, Estonia has made a bid to the Global Fund²⁹ to provide treatment for HIV. There is no provision within the prison budget this year to pay for the services of NGOs; however, there is money to enable them to buy in some training. One problem identified was that many of the medical staff working in the prisons were employed during the Soviet era. They have not been re-trained and:

it is not in their culture to ask enough from headquarters and they don't ask for enough in their budgets. (The Health Care Adviser, Prison Department, May 2003)

The Hungarian Prison Service Health care budget has increased quite substantially this year (2003). In addition, the Hungarian National Health Service provides the Prison Service with additional money each year. The Prison Department also receives all operational costs (including medicines) from the National Health Insurance Scheme. The head of health care considers that there is enough money allocated for medical equipment despite the budget reduction every year (Heylmann, Prison Department 2003). The director of the Forensic Observation and Psychiatric Institute in Hungary also felt that the budget was never enough, although it allows for the most essential things. At Baracska National prison, the prison director considered the budget for health care inadequate. They usually have to ask for more money at end of the year because the store of medicines for prisoners with chronic health problems has been exhausted.

The prison administration in Latvia cited budget constraints as a major problem, particularly a shortfall in the amount needed for refurbishment of prison buildings. Despite this, they report that substantial progress has been made in refurbishment since the 1990s. In particular, health care facilities have been developed. As an example, part of this year's budget (2003) will be used to build a TB hospital with 150 beds and, according to the prison administration, the prison hospital will continue to be reconstructed. However, the budget for prison health care is decreasing and there is not enough money allocated by the government to meet all the requirements:

29 The Global Fund to Fight AIDS, Tuberculosis and Malaria was created to dramatically increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need. As a partnership between governments, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing.

each year the prison service makes demands and we don't get active support from the government. We have made the budget for next year and informed them of the problems and we have to wait to see if we get the budget in the autumn. (General Director of the Prison Administration, 2003)

Lack of resources was also cited as a major problem when discussing initiatives to improve the living conditions of the prisoners and establishing rehabilitation programmes:

The budget is too small and we got 4 per cent less for the second half of the year. We can't buy clothing for the women and have to depend on charity, also for shoes and bed linen, as it is difficult to find the money for this. Some parts of the prison require renovation and the first priority is for the young prisoners and the children's home. (Staff, Ilguciema prison, 2003)

The Director General of the Lithuanian Correctional Affairs Department noted that there was inadequate funding allocated for medicines and personnel. Although the salaries in prison are slightly higher than those in the community, it is not enough to attract more people to come to work in the Correctional Affairs Department. A lot of the prisons are very old, as is the prison hospital, and the strategy is to use the funds available for renovation rather than building new prisons. Rather than build a new prison hospital the aim is to convert one of the community hospitals that are due to be closed. The director at Kaunas Juvenile Remand prison and Correction House said that he had received additional funding to improve the conditions for the young prisoners. The director was very positive because the Correctional Affairs Department is currently prioritizing the improvement of juvenile prisons. The prison has recently built a sports hall with external funding from the UN.

The current budget for health care in Romanian prisons is considered sufficient to ensure that prisoners receive treatment and preventative care. Equipment is paid for by external sources. The health insurance companies receive money from the General Directorate of Penitentiaries to cover prisoners' use of community services. Some of this money comes back to the prison hospitals. The head of health care at Rahova prison said that more money was needed for medicines and equipment. They also needed another doctor but it was difficult to recruit medical staff, even though the wages are better in the General Directorate of Penitentiaries than in the community. A barrier exists that makes people reluctant to work in the General Directorate of Penitentiaries.

Although both of the sample prisons had been allocated a budget for refurbishment of the prison, the directors indicated that they would have liked more money to improve and upgrade the environment. For example, at Târgșor prison, the heating system needs to be changed.

In Slovakia, while the budget for health care was considered never to be enough, the head of health care at the Prison Service Department said that 'while we can live with the current budget we do need another prison for Bratislava and to pay for the continuing refurbishment of the prisons' (Head of Health Care Prison Service Department 2004).

Problematic drug users in prison

In the Czech Republic, Estonia, Romania, and Slovakia, there is the expectation that the prison system will be receiving more problematic drug users in the future, reflecting wider societal conditions. Similarly, as in the community, the rising numbers of drug-dependents in prisons is perceived as one of the biggest challenges for the Latvian prison system:

prisons mirror society and we are besieged by all the problems affecting society at a given moment in time – the rising numbers of drug addicts, HIV-positives and those suffering from AIDS, tuberculosis and other infectious diseases. It is only by working in close collaboration with other ministries and departments and non-governmental and international organisations that we will be able to combat such problems and minimise the harm and danger that these pathologies represent for the surrounding population. Our priorities in this sphere are coordinated with those of society, and this is enabling us to make tangible progress. (Drug Law and Health Policy Resource Network, 2002)

The Bulgarian prison system is experiencing an increase in the number of drug users in prison. In 2001 there were 250 drug users in the prison system but by 2002 this had risen to 476 (Department for Punishment Execution, June 2003).

Staff at the Prison Department in Hungary argued that it was impossible to provide statistics about whether the number of drug users in prison was increasing.

In Lithuania the total number of identified drug users among prisoners in January 2001 was 852 (8.8 per cent of all prisoners), rising to 1,464 (13.3 per cent) in January 2003. While these numbers don't detail the quantity of drugs being consumed, or what drugs are being used, they do provide an indication of the problem of drug use in prisons in Lithuania:

at the moment neither the medical staff nor the officers nor even the inmates themselves can define that [what drugs are being used]. After having analyzed the official statistical data we can state that the main drugs in prisons are opiates, which were being used by 77.7 per cent of the identified drug users. Over 10 per cent of both sentenced and pre-trial prisoners use several drugs at the same time. The identified drug users in prisons rarely use cannabioides (0.9 per cent), cocaine (0.5 per cent) or hallucinogens (0.4 per cent). (Semenaite, Correctional Affairs Department, 2003)

In Slovenia drugs are perceived to be a problem in Dob prison, especially during the last two or three years where the situation in the prison reflects drug use in wider society (Prison Director, Dob prison 2003). According to some specialist staff at Ljubljana prison, 130 of the 220 prisoners are drug users and only five are seriously interested in abstinence.

At the time of the visit to Poland, the proportion of drug users in prison was estimated to be 30 per cent. Another 30 per cent of prisoners were estimated to have alcohol problems.

Drugs in prison

Some prison systems were more willing than others to officially acknowledge that there were drugs in prison. The availability of drugs in prison differed between institutions in a given country and between the different countries. In some countries the reason given for drugs not being available in the prisons was that the prisoners did not have money to buy drugs, or that drugs were not as yet easily available in the towns and villages near to some of the prisons. In other countries drugs were available in the prisons and some prisoners were injecting and sharing needles.

The Director of Lovech prison in Bulgaria felt that the amount of drugs in the prison was not a serious problem but that some people try to smuggle drugs in, usually soft drugs. He revealed that there was a greater likelihood of finding drugs in the open or transitional hostel.

Currently, most prisoners do not have the money to buy drugs. In addition, the prison psychiatrist said that, as yet, there were not many drugs available in the local town of Lovech. Prisoners in the focus group at the prison also stated that there were no drugs available. However, they felt this was because they were too expensive to buy rather than due to difficulties in getting drugs into the prison. The doctor at Varna prison said that it was impossible to say whether prescribed medications were sold amongst the prisoners or not but that it was, of course, possible:

a lot of prisoners request tranquilizers. Special medications are only given at special times and I am there then and this is a kind of prevention due to the increasing number of problematic drug users in the prison. Plus there are random checks [for drugs] made by the guards. (Doctor, Varna prison, June 2003)

The question relating to the availability of drugs in prisons in the Czech Republic gave rise to much discussion with differing viewpoints. At Opava prison the prison director argued that:

LSD is smuggled into the prison on stamps, in clothes, in food. The prison manages to stop big amounts of drugs coming into prison but can't stop the small amounts. So there are some drugs in prisons but they are not a problem as they are controlled and abstinence can be provided.

Prisoners from the focus group at Opava prison (2003) thought that:

there are so many drugs available today. You can buy drugs anywhere today. You just go out behind the gate here at the prison and somebody is offering you something. Drugs are not so common in prison but you can smuggle an elephant into the prison. When you get something [some drug] in here you can get double the price for it.

Both prison staff and prisoners at Viljandi prison in Estonia considered there to be few drugs in the prison, as the prisoners' friends and relations could not afford to buy them. There had been some cigarette smuggling as the juvenile prison was a non-smoking prison. It was also considered to be difficult to get drugs into

Tartu prison, although some drugs had been found in some sections and drugs had been thrown over the wall. Some needles had also been found in the prison. Prisoners in the focus group at Tartu prison, when asked if drugs were being used, thought 'that it is extremely difficult to get drugs into this prison and prisoners are not dealing in prescribed drugs either'; however they said that 'although drugs are not available in this prison, in other prisons, narcotic substances are available and prisoners use them'.

In Hungary it was argued that while there were about 8 to 10 drug seizures per year (compared to the seizure of 80 mobile phones), the amount of drugs in prison was not high (Prison Department, 2003). In Budapest Central prison, there is some use of cannabis and testosterone. Prisoners are generally too poor to be able to buy drugs and no injecting occurs in the prison. The prisoners in the focus group agreed that to inject in the prison was not usual. Drugs were considered to be an increasing problem in general but at Baracska National Prison the situation was considered to be better than average, with few drugs getting into the prison.

The existence and use of drugs in Latvian prisons is officially acknowledged. Drug testing (urine test) is obligatory and prison staff decide when and whom to test. The exact amount of drugs and how and when these get into prisons are unknown. The drugs most commonly used are heroin, marijuana and amphetamines. Staff estimate that there are up to 50 people sharing needles at one time in some Latvian prisons. As a member of staff in one of the prisons visited said:

there are drugs in the prison. Injecting is happening and needles are thrown over the walls and don't come from the medical department. They probably do it [sharing needles] in groups of those who are [HIV] positive and those who are not. (Staff, Pārlielupes prison 2003)

Similarly, the number of prisoners who are using drugs is increasing in Lithuanian prisons:

prisoners are considered to be the group of the highest risk from the point of view of drug usage and distribution. Many of them have been using drugs before entering prison. Others start using drugs from despair while in prison, having assumed that they have become outcasts, crushed and condemned by the community. The ultimate means the best in their opinion, to improve their conditions is "an escape" [using drugs]. (Semenaitė, Correctional Affairs Department, 2003)

Drugs are considered to be more available in Polish prisons than alcohol. The Central Board of the Prison Department acknowledges that there are drugs in prison. According to the President of the Polish Association of Probation Officers, the reason for this is twofold. On the one hand, Poland has become a country for drug trafficking and, on the other, the demand for drugs, especially among young people, is high because they are living in a period of extreme transition. According to Sierosawski³⁰ (2003), until the mid-nineties the drug problem in

30 Institute of Psychiatry and Neurology in Warsaw

the Polish penitentiary system was of marginal importance because of limited drug use in general and liberal drug legislation. It was only at the beginning of 2000 that a research project, undertaken by the Institute of Psychiatry and Neurology in Warsaw, provided evidence of the scope of the drug problem in Polish prisons.

A representative sample of 1,186 men held in penitentiary institutions all over Poland demonstrated that almost every fifth inmate had been an occasional user of drugs such as cannabis, amphetamines, ecstasy or cocaine prior to imprisonment. This figure increased to 30 per cent for those in the age group 17–24 years. The results of the study showed that within the prisons, 22.5 per cent of all prisoners interviewed and 33 per cent of those aged between 20–24 years old used drugs. These were predominantly sedative drugs such as tranquilizers, cannabis-based products and amphetamines. In all, 3.3 per cent of prisoners confirmed intravenous drug use, while 1 per cent reported sharing of syringes. According to those being interviewed in prison, the access to illicit drugs was easier than to alcoholic beverages.

In Romania it was considered possible that drugs may be getting into the prisons as there were not enough staff to search all the packages being brought in. However, fewer cases had been discovered recently. Additionally, since drug dogs were so expensive, the General Directorate of Penitentiaries did not, as yet, have one. As an added precaution, all staff are checked for drugs when they come into the prison.

It was considered to be more likely that prisoners were using prescribed medicines illegally within the prison (General Directorate of Penitentiaries, 2004). Drugs were not considered to be available in Rahova prison as the security of the prison is strong and packages are checked very strictly (Prison Director, Rahova prison 2004).

The Slovakian Prison Service has identified drugs as a problem that is getting worse. Both staff and prisoners from the sample prisons thought that there were very few drugs in these prisons. However, both groups indicated that drugs were more easily available in other prisons in Slovakia.

The drugs usually found in Slovenian prisons are mainly heroin and marijuana but amphetamines and benzodiazepenes are also problematic. The drug causing most concern to the prison administration is cocaine because if a prisoner, who shares his room with 13 other prisoners, uses cocaine there could be serious problems involving aggressive behaviour.

Communicable diseases

Voluntary testing for HIV was available for prisoners in most of the prison systems but in three countries, only if the patient was symptomatic. Testing for hepatitis C was not routinely done in any of the countries.

According to the head of health care at the Bulgarian Department for Punishment Execution, prisoners are tested for syphilis, hepatitis A, B and C and are also offered an HIV test. The HIV test is voluntary but prisoners do request to be tested. Neither of the sample prisons routinely tests for hepatitis, but prisoners

are tested when they display symptoms of the disease. There have been approximately 60 cases of hepatitis A reported at Lovech prison.

The prison doctor who works mainly with drug users said that out of the twelve prisoners he had tested, six were hepatitis C positive. At Varna prison there was one prisoner with hepatitis B and three with hepatitis C. There were no cases of HIV in the two sample prisons visited; this mirrors the situation in the community amongst injecting drug users, where there are very few cases of HIV.

In the Czech Republic, there are no official statistics about how many HIV-positive prisoners there are in the prison system. There were no cases of HIV at either of the Czech sample prisons at the time of the visits. Among the drug users in Opava prison, 11 have hepatitis. Those who have hepatitis are taken to a specialist unit in the hospital in the local town where they have further tests and receive treatment. At Příbram prison there were 25 prisoners with hepatitis C.

The current focus of prison health care in Estonia is on injecting drug users and the spread of communicable diseases. The prison health care department tested 2,087 prisoners across the prison estate in 2001 and found that approximately 23 per cent were HIV-positive. These test results indicated that the majority of HIV-positive prisoners were infected via intravenous drug use prior to reception into prison and only two prisoners became infected while in prison.

There is not a specific programme for hepatitis C and not all prisoners are tested for the condition – only those where there is a suspicion that they may be infected. Additionally, only the symptoms of the disease are treated. No one in Estonia currently receives interferon treatment.

At the time of the visit there were only two cases of hepatitis in Viljandi prison: one person with hepatitis ABC and one with hepatitis C. At Tartu prison, there were a high number of HIV cases with 122 men and 7 women infected (May 2003). There were also 160 cases of hepatitis B and 207 cases of hepatitis C. The HIV infection is related to drug addiction; for example, of the 27 women prisoners six of the seven who tested positive for HIV were also injecting drug users.

In Hungary there are nine known cases of HIV-positive prisoners who are still segregated at Tokol prison. Since the beginning of 2003, HIV testing has become voluntary in prison. Since the introduction of this initiative, sixty per cent of prisoners have agreed to be tested. However, the number of prisoners who agree to be tested is gradually reducing. The counselling available for pre- and post-testing depends on the individual in charge of the particular health care centre in each prison. Due to staff problems and shortages, the central protocol for testing does not occur in all prisons. Treatment for hepatitis C is available from the Central prison hospital. Prisoners are not specifically screened for hepatitis C unless they are blood donors.

In Latvia, not only is the number of HIV-positive prisoners critical, but the number of prisoners with tuberculosis reached 580 in 1998 (Nils Muiznieks *et al.*, 1999). At Ilguciema prison, there were no cases of acute hepatitis. Currently the prison does not have a budget for treatment for hepatitis and a decision would need to be made by the prison hospital whether to provide therapy or not. There are 73 HIV-positive women in the prison and of these, 52 have hepatitis C and two hepatitis B. Only the HIV-positive prisoners are offered the hepatitis test.

At Pārlielupes prison there were no cases of hepatitis A or B but there were 53 people with hepatitis C (8.4 per cent of all prisoners). The head of health care at Pārlielupes prison estimated that there were 69 prisoners who were HIV-positive (2003).

At Alytus Correction House in Lithuania there had been an outbreak of HIV infection amongst prisoners. Between 17 May and 20 June 2002, the Correctional Affairs Department and the Lithuanian AIDS Centre carried out a survey at the prison and identified 207 cases of HIV-positive prisoners. The survey was repeated in July 2002 and a further 77 prisoners were identified as HIV-positive. Forty-four of these 77 prisoners had been found to be HIV-negative during the previous survey in May 2002. In total, during the period between May and August, 299 new HIV-positive cases were identified. The cause of this HIV outbreak was established to be a result of injecting drug use in the prison. The identification of this number of HIV cases caused concern in Lithuanian society:

because of the fact that the new cases had been diagnosed in an isolated area, i.e. in the strict regime of Alytus Correction House. Since 1988, all the persons who are punished with imprisonment are tested for HIV in Lithuania, therefore such an HIV outbreak was unexpected by the specialists. A social survey among prisoners was carried out in order to find out what information about HIV/AIDS they needed. (Aplinskas, 2002)

As the amount of HIV increases in Lithuania, the number of prisoners who are HIV-positive is also increasing. The majority of known HIV-positive prisoners coming into prison are already registered at the AIDS Center. There are also cases where HIV is diagnosed while in prison (Semenaitė, Prison Health Care, Correctional Affairs Department, 2003). Hepatitis is another acute problem closely connected to drug injecting. Not all prisoners are tested for hepatitis, as there is not a regular procedure like the one for HIV testing. At Alytus Correction House, hepatitis C is considered to be a problem, with a high percentage of HIV-positive prisoners also infected with hepatitis C.

In Poland there are no official statistics collected on hepatitis B and C in prisons.

Routine testing for hepatitis C is not carried out in Romanian prisons but is undertaken if prisoners are symptomatic. The incidence of infectious diseases in the prison system is high. In 2000 the number of known HIV cases in Romanian prisons was three times higher than in 1999 (despite only prisoners with identifiable symptoms being tested for HIV).

In Slovakia there are low numbers of HIV-positive prisoners. The prison regulations state that 'risk groups' should be tested (IDUs, homosexuals and those with STDs). Since 1998, 20,000 prisoners have been tested for HIV and three prisoners have been found to be HIV-positive (Head of Health Care, Prison Service 2004). Prisoners are only tested for hepatitis C if it is suspected that they may be positive.

At Bratislava prison, between January and September 2001, 231 injecting drug users (IDUs) in the prison were tested for hepatitis C and 49 of these were found to be positive (21 per cent). This testing was only done in Bratislava prison because approximately 80 per cent of drug users come from Bratislava.

(Throughout the prison system there were 696 drug users and 334 (48 per cent) came from Bratislava.)

In the research carried out by Joze Hren about risk behaviours in Slovenian prisons, the majority of respondents confirmed that they were hepatitis B positive and 3.7 per cent were hepatitis C positive. It can be assumed that some of these inmates were both hepatitis B and C positive. The results from Hren's (2002) study showed that 1 per cent of the sample of prisoners confirmed that they were HIV-positive. HIV testing is not routinely offered to all prisoners. Prisoners are only tested if they are known to be injecting drug users or they confirm that they have been involved in risk behaviour

The provision of counselling for pre- and post-testing is a key issue in dealing with increasing prevalence of HIV in prisons. The development of counselling is different amongst the sample countries.

In Estonia the prison department health care adviser felt that the standard of pre- and post-test counselling provided was in need of improvement and this is an area where further training will be provided. In Poland, prison staff (psychologists, case managers, and some medical staff) have been trained in pre- and post-testing counselling. In practice however, psychologists and case managers are seldom present at the time of testing and the medical staff who do the actual testing, are not always qualified to conduct pre- and post-test counselling and would refer the patient to a psychologist. However, issues of confidentiality do not always make this possible.

In Hungary the pre- and post-test counselling available depends on the person in charge of the particular health care centre in each prison. Due to staff problems and shortages, the central protocol for testing does not happen in all prisons.

In Lithuania pre-test counselling is provided by prison medical staff if a prisoner has a positive HIV test result, counselling is done by a specialist who previously worked for the AIDS Centre and who is now employed in the prison hospital. In a project with the NGO ARAS [Romania], staff in the fourteen pilot prisons have been trained to provide pre- and post-test counselling for HIV.

Activities and availability to work

The opportunity to be engaged in meaningful activity is an important factor in prisoners' overall sense of well being and health, especially in situations where they have very limited time out of cells and where the cells are overcrowded. The prison administrations in the study generally emphasized the importance of providing work for prisoners:

In accordance with the principles set out in the European Prison Rules (Rule 71) work is seen as a positive element in treatment and training: it is also recognized that as far as possible the work undertaken should contribute to a prisoner's ability to ensure a normal life after release. (Walmsley, 2003:74)

There is only enough work for 25–30 per cent of the prisoners in Bulgaria, which mirrors the situation in general society. The work is normally with metal, wood

and ceramics. However, prison workshops are not competitive with the outside world.

Every day that a prisoner works counts as two days of their sentence which, as the director of Lovech prison pointed out, is a good incentive. However, it also discriminates against those who want to work but are unable to do so because of the shortage of available work.

At Troyan prison, which has 500 prisoners, approximately 100 of them work, with half of them doing manual unskilled work in the community. Work in the prison is in two areas of production – metal work and soft furnishings. There is also some agriculture and farming; the produce is used in the prison and also sold in the community. Most prisoners who go out to work do so in groups of 20 with no guards present and so far there have been no problems. This is an exception to the regulations as a reward for good behaviour and acts as an incentive to the prisoners.

The schedule for those who are not working is sports, movies and meetings with outsiders. There is a school for recidivists offering 1st – 12th grade, run by the Ministry of Education. None of the prisoners in the focus group was working. They felt that:

if you were known as a drug addict then you didn't get work. There is only one psychologist in the prison and he decides the treatment based on nothing. We don't get any help from anybody. We all want to work so that we could be released earlier. But all we do at the moment is stay in the prison locked up. This prison is very bad at dealing with drug users and Varna prison is much better; it is more like a hotel. We would like better conditions, the ability to work so we would have access to the privileges, and for there to be no discrimination towards drug using prisoners. (Prisoner focus group, Troyan prison, June 2003)

At Lovech prison, as required by the regulations, one television is provided per section but prisoners can also have their own TV. Radios and walkmans are also allowed and prisoners can write unlimited letters. Prisoners are able to be outside for one hour per day and there is access to a fitness centre, which can be used up to five times per week. However, this facility was not considered to be very good by prisoners in the focus group. There are also some sports available for half an hour during the day for the prisoners.

In the main prison in Varna about 70 prisoners are working. The opportunities for prisoners to work are minimal and there are not enough activities to fill their time:

if we had more money we could provide more jobs and ways of filling the time and change the prisoners' attitudes to work. (Specialist Staff, Varna prison, June 2003)

The prisoners work on a rota within the prison. This is regulated by community legislation. The new law says that it is not mandatory to find prisoners work; rather, it depends on their skills. Prisoners in the transitional prison, however, always have access to work.

There is a prison newspaper produced at Varna prison, which is distributed to the other prisons as well. All of the prisoners can contribute to this newspaper.

There is also an art group in the prison, as there are a number of artists amongst the prisoners. With the help of the regional government, three exhibitions of prisoners' work have been held outside the prison. There are good links between the prison and the local neighbourhood and the prison is receptive to working with the community. Some prisoners have volunteered to work and help with city projects (building).

Various activities are provided for prisoners such as sports, TV, videos, and religious activities. Prisoners from the focus group said that during the day they could watch cable TV. Table tennis would normally be available but the prisoners reported that the table is currently broken.

Prisoners have access to education if they want it, especially if they are illiterate. Illiteracy in the prison is predominantly amongst the ethnic groups. A course was recently funded by a foundation tailored to meet the needs of illiterate prisoners. The staff teaching on the programme were recruited from the same ethnic groups as the prisoners to act also as role models and the course was considered to be very successful.

There are vocational courses that are centrally organised for cooking, tractor driving and commerce. The prison has up to 20 courses per year for up to 20–25 people per course, but this depends on financial constraints, as it is usually funded from outside the Department for Punishment Execution. The prison director reported that there was a problem in motivating prisoners and this resulted in a high drop out rate from the courses provided.

At Opava prison in the Czech Republic, there is a high employment rate with 60–65 per cent of prisoners working. This is 20 per cent above the national average. The prisoners are employed in the prison and also in the community. Staff at the prison thought that prisoners working outside the prison was a good thing:

prisoners go out of the prison to work, which is good, and it takes them away from the isolation of being in prison; they get to mix with other people. People outside do not find it strange anymore to have prisoners working with them. (Opava prison, Specialist Staff 2003)

When the prisoners come back from working outside they are subject to random checks for alcohol and drugs. Some of the women prisoners are not employed due to health reasons. Unemployed prisoners tend to have short-term sentences, are older (and on pension) and/or are incapable of working due to health reasons (Opava prison, Prison Director 2003). Vocational training in seven areas is available at Opava Prison. Education is also available for both the adult and juvenile prisoners.

The availability of work for prisoners at Příbram prison has changed post 1989:

the history of the prison is that it used to be a work camp: prisoners worked in the (uranium) mines with civilians, but slept at the prison. It was a military regime but prisoners had a job and got paid for it. Prisoners at that time used to exchange work with civilians for medication. At that time there were fewer riots, less stress as prisoners could freely circulate in the prison, going to work and back at the prison and earned money. Post 1989 there is less

work; now only 40 per cent of prisoners are employed but there are more activities, courses, etc. (Příbram prison, Prison Director, 2003)

The work available in the prison is mainly maintenance and requires basic skills. Prisoners who are unwell or unfit to work are kept busy through some kind of work or activities. Three companies work in the prison undertaking wood processing, the manufacture of paper products and the assembly of plastic products (Příbram prison, Prison Director, 2003).

In Estonia all the prisoners in the young offenders prison either attend educational classes or vocational training and some are involved with the maintenance of the prison. The vocational training provided is in furniture upholstery, metal work and bricklaying. Education is compulsory until they have passed 9 grades. Prisoners who attend education do not get paid but those on vocational training or working on maintenance of the prison do. In Tartu prison only sentenced prisoners are entitled to work, with one third of this group working inside the prison. The prison was aiming to have the remaining two thirds of prisoners working within the next six months.

School education and vocational education is provided for prisoners in Hungary and approximately 2,300 prisoners per year attend such courses. The vocational courses that are offered are not always accredited but in 2003, 889 prisoners did receive vocational qualifications.

At Budapest Central prison, sentenced prisoners are expected to work if employment is available. Only 60 per cent of the prisoners however, are able to work. The types of work available include making furniture and footballs and the manufacture of skeletons. Prisoners can also access education and vocational training. Only one of the prisoners on the drug prevention unit was working:

there is nothing special happening on this unit: there is a ceramics workshop but that is not operating currently. If it was working it would make it more interesting here [on the drug prevention Unit]. (Prisoners focus group, Baracska National prison 2003)

According to the law all prisons should provide work for prisoners but at Baracska National prison, it is only possible to provide work for about 45 per cent of the prison population. 95 per cent of the prisoners are capable of working however and the remaining 5 per cent cannot work due to health reasons. Baracska National prison has a *Limited State Company* for agriculture and related services that provides work for prisoners. The prison has 1100 hectares of agricultural land attached, where grain and sunflowers are grown. Animals are also bred and there is a slaughterhouse. The prison also processes vegetables and fruit.

In Ilguciema prison in Latvia approximately 70 per cent of the prisoners are able to work either in the prison or in the nearby town. The prison tries to divide the available work into shifts to give as many prisoners as possible the opportunity to work. Some work is available for pre-trial prisoners, with approximately 16 per cent of them making paper bags. Availability of work was minimal in Pārlielupes prison with only 29 per cent of prisoners able to work. Prisoners in the focus group complained about the lack of work available and the low wages they received for it.

Vocational education is not widely available in Latvian prisons. In Pārlielupes prison seventy-two prisoners were receiving vocational training. Those prisoners who successfully complete the vocational training receive a diploma, which does not indicate that the training took place in prison. In Ilguciema prison there is a school for the juvenile prisoners and they have to reach 12th grade. There is also a craft school. The community runs the classes, as the prison doesn't have money to pay for them. The prison provides the premises and security for staff.

The lack of work, vocational training and educational opportunities available in Latvian prisons is officially acknowledged:

one third of prisoners are willing to change their criminal behaviour and the state should help them to maximise this. We are gradually trying to resolve these questions by developing proposals to the government to initiate changes to provide more rehabilitation opportunities for prisoners. (Director General of the Prison Administration, 2003)

In the Lithuanian prison system about 25 per cent of the prison population are working. About 40–45 per cent of prisoners don't want to work (Director General, Correctional Affairs Department). According to the penal code:

work is a duty for prisoners. The administration of an institution must ensure that inmates perform a job, which corresponds to their working capability and specialty. Normally, inmates work in the enterprises of institutions. Prisoners below the age of 16 years must attend school. Other prisoners are involved in educational programmes only if they wish so. Prisoners without a specialty or profession must participate in vocational training programmes. If inmates are willing, the programmes for upgrading the existing skills and for training in new specialties can be organised in the imprisonment institutions. (Švedas, 2000: 38)

All the prisoners at Kaunas Juvenile pre-trial prison and Correction House attend the school. The juveniles usually have not attended school regularly prior to imprisonment. A key role for the educators in the prison is to motivate the juveniles to study, as they are not keen to attend school. The prison also offers vocational training. The courses offered at the moment are industrial sewing and carpentry and 75 of the juveniles attend the courses. There is only work for a low number of the juvenile prisoners in the manufacturing field, baking bread for the prison and working in the prison laundry.

In Alytus Correction House around 300 prisoners are able to work. The prison finds it difficult to find jobs for the prisoners due to the competition for work in the community. Approximately 100 prisoners are studying for their high school certificate. There are also some opportunities available for vocational training in four areas that accommodate 180 prisoners.

In Poland prisoners have a 'duty to work' under the new Penal Executive Code. But at the beginning of 2001 only 27.2 per cent of sentenced prisoners were employed, and less than 21 per cent were in paid work' (Walmsley, 2003: 410).

In Montelupich prison there was only work available for 20 per cent of the prisoners. At Sluzewiec prison, approximately 57 prisoners were working at the

time of the visit. The percentage of sentenced prisoners working in the prison changes, depending on the outside job market. Outside employers are reluctant to employ prisoners for a variety of reasons: concern with security issues, the formalities that are required to be fulfilled, the level of prisoners' education and a general negative attitude towards prisoners.

In Romania the activities and programmes that are available to prisoners are organised by the educators in the prisons. Educators come from different educational backgrounds with different specialisms. The number of prisoners that an educator is responsible for depends on the number, and type, of prisoner. The average is one educator per 200 prisoners but the ratio tends to be lower with juvenile prisoners where there is an emphasis on rehabilitation, retraining and education.

The General Directorate of Penitentiaries in cooperation with the Ministry of Education provides a range of vocational training and education. This is considered particularly important because the educational level of prisoners is poor, often falling below basic literacy skills.

Some prisoners are engaging with higher education while in prison. At the time of the visit, approximately five or six prisoners were studying for a degree. Prisoners who pass training or education courses in the prison receive a certificate that does not indicate that the qualification was achieved whilst in prison.

Educational and cultural programmes in each prison are co-ordinated by the Social Education Department. The programmes offered in individual prisons are dependent on the skill mix of the educators. The programmes are voluntary but generally the prisoners are keen to take part. There is a wide range of cultural activities provided: for example, around 15 prisoners in each prison are involved with glass painting. In particularly skilled activities, such as sculpture, an instructor from the community will be employed.

Prisoners from the focus group at Rahova prison appreciated the cultural activities but felt that the time available of one hour per week was not enough.

It is not mandatory for prisoners to work while in prison. However, prisoners who are working can get a day off their sentence depending on the type of work and the number of days worked. For example, for every two to four days worked they get one day off their sentence. The availability of work for prisoners depends on the economic situation in the local community. In Romania in general there is currently high unemployment and this makes it quite difficult for prisoners to be given work. There are jobs for approximately twenty five per cent of prisoners, which increases in the summer to between 30 and 35 per cent.

At Rahova prison, approximately nine per cent of prisoners are able to work, mostly within the prison itself. There are two or three prisoners in each section working as cleaners, 13 in the prison garage, 12 in maintenance of the prison, 20 in the kitchens, 20 in the carpentry workshop and 40 who work on the prison farm. When the prison contracts out to external companies, prisoners will work with these. This is very popular with prisoners as for every four days a prisoner works they earn one day off their sentence. The director of the prison would like to develop space in the prison for a factory to provide more work for the prisoners.

At Târgșor prison 55 per cent of the prisoners can work, which increases in the summertime to 80–85 per cent. About 100 prisoners are unable to work because

of age or illness. Prisoners are able to work on the prison farm or for outside companies. The prison possesses a clothing workshop that employs 200 prisoners and provides vocational training for the clothing and agriculture industry. The majority of prisoners in the focus group were working in the clothing workshop and they felt that the training certificate they would receive would be useful when they are released.

At Ilava prison in Slovakia over 50 per cent of prisoners are working although the director would like all prisoners to be able to work. In reality, not all of the prisoners are fit to work due to 'low educational ability' (Prison Director, Ilava prison 2004). A range of activities is provided for prisoners and they can also use the library and participate in sports activities.

Approximately 68 per cent of sentenced prisoners in Sučany-Martin prison are working. If work cannot be found for juvenile prisoners, they participate in education. A high number of the prisoners have not completed elementary education and they are encouraged by prison staff to achieve this qualification while in prison. The prison social worker can also arrange for prisoners to study for higher education during evenings. A range of vocational courses is available to prisoners in the fields of carpentry, cooking and restaurant service. It is possible for prisoners both to continue with vocational training that they started in the community and to continue with vocational training after release from prison. Prisoners are also allowed up to five days leave from the prison each month to take exams and other assessments.

The type of work available to prisoners in Slovenia varies and depends on the demands from the community. Women prisoners tend to do book binding and male prisoners tend to do industrial work. There are no private companies working in any of the prisons. Prisoners who work receive one quarter of the salary they would get outside for the same job. Two members of the prison administration expressed the opinion that the:

work provided in prison tends to focus too much on the economic side when it should be more about the social value linked to working, especially for drug users who often have never worked previously. Drug users in prisons are supposed to work eight hours a day, but they tend to do only two hours a day because they lack perseverance and they don't have the work ethic. (Head of Communication and International Affairs and Head of Health Treatment, National Prison Administration 2003)

At Ljubljana prison, the work available inside the prison is domestic, maintenance, laundry, kitchen and workshops. Fifteen prisoners work outside the prison in a factory in the city that the prison has enjoyed very good collaboration with for many years. If the prisoner had a job prior to imprisonment, outside factories are more likely to employ them. Dob prison has a state owned factory inside the prison that provides over 200 jobs. At the time of the visit there were vacancies in the factory as only 150 prisoners were working.

There is formal and non-formal education offered to prisoners: *formal* education is provided in cooperation with external associations (community based education units, secondary and higher education, etc.) and is provided for about

twenty prisoners per year covering primary, secondary and higher levels of education leading to certification.

The education is provided both in and outside of the prisons. Usually, it is prisoners and their families who pay for education but in some cases, the prison may pay for it. At the time of the visit, there were no formal links between the Ministry of Justice and the Ministry of Science, Education and Sport:

the Ministry of Education is preparing a document (to be ready in 2010) on 'education for adults'. Prisoners should be included in this document (prepared for the European Union). Prisoners can get education while in prison, though more could be done. 210 prisoners (about 20 per cent of the prison population), including juveniles and adults are engaged in education (Head of Pedagogues, National Prison Administration 2003)

Dob prison pays for approximately 73 per cent of the prisoners who are engaged in formal education. 78 prisoners are involved in non-formal education and about 4 per cent of the prisoners engaged in non-formal education (free time activities) have a history of drug use. Prisoners who are on a methadone treatment programme get the same opportunities for education as the others.

Sex, prisoner hierarchy and bullying

The discussion as to whether sex³¹ in prison is occurring, and thus a potential risk area for the spread of communicable diseases, is a very sensitive issue both with prison staff and with prisoners. There is a reluctance to discuss it because of the taboo surrounding sex and because homosexual behaviour is often illegal itself. Sexual activity in prison can also be linked to the prisoner hierarchy and bullying:

this complex power structure is essentially the same throughout the countries of the former Soviet empire, with local variations. The system in itself is of Russian origin, but since in Soviet times prisoners were transferred all over the territory of the Union it subsequently became the norm everywhere. The well-established internal hierarchy among prisoners is best described as a "caste system". It is within this system that violence among groups of prisoners can be extreme, and can involve sexual practices that put large numbers of prisoners at high risk of catching STDs and HIV. (Reyes, 1997a)

It is not uncommon in prisons for there to be power structures that run parallel to the official administration. In some situations, these prisoner hierarchical structures can be more powerful than the official prison authority:

Prisoner culture obviously varies between countries, and prison populations are anything but homogeneous, even within a single establishment. One common denominator in all prisons, however, is the existence of power

31 Unprotected anal or vaginal sexual intercourse poses the greatest risk for transmission of HIV. Damage to the mucous membranes of the vagina or anus increases the risk for HIV transmission for the receptive partner.

structures parallel to the official administration. In many cases this unofficial hierarchy is more powerful than the official authority, and prison administrations often condone these parallel systems as they help to maintain order. The type of prison society that results will of course depend on many factors. (Reyes, 1997)

The prison environment, especially in periods of overcrowding and staff shortages, can lead to bullying especially for those prisoners who find it difficult to cope with prison life. The existence of the prisoner hierarchy is also important as it impacts on prisoners who are HIV-positive as will be discussed later in the report. The response to sex, prisoner hierarchy and bullying within the sample countries was varied.

The head of security at Varna prison in Bulgaria made an interesting point about how the prison hierarchy is changing as the current prison population is now much younger, with higher numbers of drug users. As a result the 'leaders' are not like before (pre-1998) resulting in new 'leaders' and small groups of prisoners who knew each other from before in the community. The psychologist agreed that the hierarchy has changed. This was particularly evident in relation to bullying, which was a problem in the prison four or five years ago when:

the prison was about survival of the fittest! And then the financial state of the country and the prison created a situation of 'survival of those with money' as they [prisoners] could buy the strong prisoners to protect them. To implement a bullying strategy in this climate of economic power is a utopian idea. We work with this problem bit by bit; some prisoners report bullying but as they are often threatened they don't report it until it escalates. Then they do. The law says that psychological and physical bullying is wrong and each reported case is investigated in the same way a court investigates a small crime. Then the bully receives a punishment. This doesn't really act as a deterrent. (Prison psychologist, Varna prison, June 2003)

Prisoners in the focus group said that bullying is normal and that it is everywhere. They confirmed that they would probably tell staff if bullying was occurring. The prisoners were very positive about their relations with the guards who were considered to be OK. They liked the fact that the guards were young and noted that some were 'nice people'.

At Lovech prison cases of bullying are dealt with by clarifying the circumstances immediately. This year (2003) three cases of bullying have gone to court. Incidents of bullying in the prison are usually amongst those prisoners who are not working. Prisoners also help the prison administration to stop the bullying. Prisoners are informed about bullying at reception to the prison.

In the Czech Republic at Příbram prison sex was not considered to be a problem as no abuse or homosexual practices had been reported. Consensual sex was thought not to happen and, as prisoners were free to report incidents and the prison had received no complaints, there was not a problem. It was also thought that the presence of security on the sections at night acted as a deterrent. In 2002 there was one case of sexual abuse between two prisoners that was reported.

Prisoner hierarchy in Estonia is a legacy of the Soviet type of camp prison and has a harmful effect on Estonian prisons. This was an issue raised by prison staff and prisoners in both sample prisons. The director of Viljandi prison said that there was a problem with the prisoner hierarchy, which:

consists of three levels – the upper, middle and lower groups. The prison tries to separate prisoners on the basis of this hierarchy to try and get rid of it or at least reduce its effectiveness. This is a slow process. (Director, Viljandi prison, May, 2003)

Prisoners in the focus group at Viljandi prison explained that:

to be on the top of the hierarchy you need to be smart, strong and able to foresee things. There are some beatings and the guards are not quick to intervene. The middle level of the hierarchy is quite big and some of us don't want to be on the top as it is better to be in the middle. It can be difficult for staff to intervene as those on the top may have contacts at the Ministry of Justice. It is not simple to learn how the hierarchy works; it took me 6 months to understand it in this prison. (Prisoner focus group, Viljandi prison)

Some prisoners in the focus group at Viljandi prison felt that the hierarchy did involve sexual activity. This took the form of those on the top of the hierarchy influencing those lower down not to have sex, but to provide 'massage'. Most prisoners' position in the hierarchy is set in pre-trial prisons and they keep this position in the subsequent prisons they are sent to.

This prisoner hierarchy is also linked to the issue of bullying in prison and operates to discourage prisoners to talk to staff when incidents occur. At Tartu prison the prison management adopted a strategy of ignoring the hierarchy and mixing prisoners together. They felt that this strategy has worked but the hierarchy system would be difficult to destroy. The prison management are trying to control bullying and there have been no major fights in the prison so far. Prisoners from the focus group felt that:

the prisoner hierarchy has been broken at this prison and life is better now. Bullying has decreased a lot but there is still some. We tend not to beat people up now, as more people will tell the guards. In addition pre-release and home leave and other benefits act as good incentives to stop bullying and fighting. (Prisoner focus group, Tartu prison)

According to the prison administration, prisoner hierarchy subculture is not as strong in Hungary as in other former communist countries of central and eastern Europe. Staff at Budapest Central prison had mixed views about the existence of such a subculture. One member of staff believed that it did not exist in the prison whereas another member of staff noted that:

the prisoner hierarchy is a serious problem in every prison and as a specialist member of staff I know about it and the managers have less knowledge and so they do little. Prisoners treat the hierarchy as a "family matter" where what happens in their room is not spoken about and it is only if someone rebels that they will talk to staff. Rape is present here as well. Lot[s] of people

have been to juvenile prisons and amongst them sex is a wide practice so those who come here will continue i.e., 4 or 5 prisoners will force one prisoner [to have sex] and this is not often detected and it is difficult to punish the perpetrator as the victim will not come forward. (Specialist staff, Budapest Central prison, 2003)

According to the prison administration, if prison staff observe evidence of prisoner hierarchy, they will try to do something about it by moving prisoners to another location in the prison to decrease their power.

In Latvia the prisoner hierarchy is inherited from the Soviet era of camp prisons and has a harmful effect on Latvian prisons today. For staff, dealing with issues related to the prisoner hierarchy is a time-consuming and complicated task. As a member of staff from Pārlielupes prison said:

there is a hierarchy amongst the prisoners; you wouldn't see it but it is there. The hierarchy does not impact on sex and bullying. It is mostly about threats and orders to make others wash their clothes for them etc. If there are sexual relations this is not necessarily linked to the hierarchy. Sexual relations do exist here and if they do it, it is up to them [the prisoners] – there is a tolerant attitude here and they do it during the night. (Prison staff, Pārlielupes prison)

Latvia's prison system has no central strategy for bullying. However, members of staff are aware of the problems related to bullying and various prison rules are designed to prevent this. For example, there is a policy to remove prisoners who bully others to a different cell or wing. Prisoners usually share their experiences of bullying with the prison's psychologist (Staff, Ilguciema prison 2003). According to a member of staff at Pārlielupes prison, dividing prisoners into different levels (of regime) prevents bullying. Although prisoners who are in prison for the first time and recidivists are not separated:

we watch newcomers carefully to check that they are adapting to prison life, coping and not being bullied. (Prison staff, Inspector of regimes and security, Pārlielupes prison 2003)

Prisoners and prison staff at both the sample prisons in Lithuania raised the problem of prisoner hierarchy. At Alytus Correction House, the prisoner hierarchy was considered to be an ongoing problem especially when prisoners are living in dormitory conditions. It is considered to be difficult for security staff to respond in terms of proving who is, for example, being forced to have sex, or whether a prisoner may be acting as a prostitute to earn money (Correction House Staff, Alytus Correction House 2003). The Director General of the Correctional Affairs Department acknowledged the problem of prisoner hierarchy. The policy being adopted was one where the leaders of the hierarchy were gradually being isolated and their potential for selling drugs reduced. Prisoners from the focus group at Alytus Correction House considered the policy of separating the hierarchy leaders negatively:

in this prison those with higher status are isolated from the others and this is very bad. Before they did this prisoners were not equal. The hierarchy just amplifies the inequality in society. The hierarchy was very strong before and

this will continue despite separating the leaders. (Prisoners, Alytus Correction House 2003)

The prisoners in the focus group at Kaunas Juvenile Remand prison and Correction House reported that in their group there was no bullying, but they didn't know if this was the same in all groups. In Alytus Correction House, some staff considered bullying to be a problem caused by the power of the prison hierarchy. The prison has adopted strategies for dealing with bullying:

if a prisoner complains of being bullied there are two solutions: either to transfer the victim to another sector or transfer the bully. There are cases of bullying about once per month so some prisoners do tell staff when it happens. At entry to the correction house I talk to newcomers about bullying and prisoners are warned about such things. At the assessment period a prisoner can ask not to be put with someone he knows on a section. (Specialist Staff, Alytus Correction House 2003)

At Rahova prison in Romania, the prisoner hierarchy was perceived as being:

definitely a problem that exists due to some unwritten rules of the prison that male prisoners keep to strictly! This is the same in all prisons across the world. Male prisoners are more discreet than women prisoners and keep issues about sex more secret amongst themselves. As a result of the hierarchy a prisoner who is homosexual has to admit it to the others in the room as they wouldn't want to touch his things. Prisoners are very homophobic here. It comes down to accepting your place in the hierarchy. Prisoners are locked in their room from 9.30 pm till 5.30 am and they are not supervised but if there is the slightest clue (from the guards or others in the cell) of problems like forced sex then the prisoner will be removed and protected. (Prison Director, Rahova prison 2004)

Bullying was not raised at Rahova prison as a problem amongst the prisoners. There is not a bullying policy at Târgșor prison for women as it is not considered to be a major problem. There are good relations between prisoners and staff at the prison and prisoners are told clearly during the assessment period that bullying will not be tolerated (Specialist Staff, Târgșor prison 2004).

According to the prison department in Slovakia, the issue of prisoner hierarchy was not a key issue:

I don't know about the hierarchies but if we find out there is forced sex we do something about it and don't hide it. (Head of Health Care, Prison Department 2004)

Prisoners in the focus group at Trenčín prison said that prisoner hierarchy was not operating there although:

it is in other prisons, mainly in larger prisons and usually amongst the third correctional groups. The main reason for the hierarchy is when prisoners are distributed into the rooms they (prison management) don't differentiate be-

tween the physical state of prisoners and their crimes. So what can you expect, if you put three strong men with a young boy? (Prisoner focus group, Trenčín prison 2004).

At Ilava prison the prison director did not see the prisoner hierarchy as an acute issue:

it can't be prevented especially in the larger rooms. There is a hierarchy in the cells but this is not explicit and if it is here we are not able to eliminate it. (Prison Director, Ilava prison 2004).

At Sučany–Martin prison, prisoners in the focus group reported that there were incidents of bullying in their section:

bullying is everywhere, here as well. When a new person comes he either becomes part of the group or he is excluded from the group. When a new prisoner comes the bullying moves to them. If he is excluded he has to wash socks, give food from his parcels to the others and so on. Forced sex doesn't happen here but it does in other prisons. Most people [who are bullied] are quiet as they are afraid to talk to staff about it. (Prisoner focus group, Sučany–Martin prison, 2004)

Prisoners in the focus group at Trenčín prison talked about self-government³² amongst the prisoners as a useful mechanism for dealing with issues like bullying:

we elect, from among ourselves, someone who has been here longer, usually more intelligent people and those who are going to be here for a while. If they fail as the leader or their sentence ends then they are replaced. Prisoners respect this system and when we can resolve problems we do; if not then we will involve the pedagogue or educator. This system also helps the staff. (Prisoner focus group, Trenčín prison 2004)

Bullying and violence in prisons in Slovenia are not considered to be major problems. Although most prisoners do not report incidences of bullying, when prison staff are made aware of cases they have a procedure to deal with them (Head of Psychology, Prison administration 2003). At Dob prison bullying was acknowledged:

there are cases of bullying; yes it does happen. The biggest problem is that the prison is overcrowded. Conflicts arise due to snoring, what channel to watch on the TV, hygiene habits and so on. Often problems arise between prisoners due to something that happened outside and they are continued in the prison. The biggest problem with these conflicts is the concealed violence, concealed by the prisoners themselves (by the victims and the aggressors). (Security Staff, Dob prison 2004)

32 This is an elected body of prisoners that is approved by the educators. If a leader is found amongst the prisoners, the educators try to use him positively or move him to another wing.

Prisoners in the focus group at Dob prison agreed that there were cases of bullying:

they put all kinds of prisoners together – child molesters and murderers, which is against logic... sometimes people who'd like to come on the drug free units can't because there are no vacancies, because other prisoners are transferred there for their protection, like child abusers/sex abusers. The staff know that these criminals are safe there, and they're not there because of drugs. The only violence is against them. No one likes them. (Prisoner focus group, Dob prison, 2003)

At Ljubljana prison, staff reported that mild bullying happened and that it was often related to drug dealing and sometimes originated from people under the influence of drugs. Occasionally the bullying was to do with arguments and fights that started outside the prison.

Suicide and self-harm

Studying intentional self injuring behaviour is complex. Attempting to screen suicide risks in prison and the decision to label someone as 'suicidal', and the many detection and intervention problems inherent in dealing with such a poorly understood phenomenon – all contribute to the difficulty in successfully developing a management strategy to prevent it. (Albanese, 1983:66)

Across the ten countries, the general view was that incidences of intentional self injury (ISI) had decreased within their prisons. In most of the countries ISI was taken to include cutting and swallowing foreign objects. The discussion of ISI in prisons is complicated by how it is detected and reported in different prison systems. Prisoners who intentionally self injure themselves are often labelled as 'attention seeking' and 'manipulative'. Whilst there may be some truth in such labels:

an attempted suicide (or actual suicide) may be the only way an individual feels that personal distress or the need to seek help can be expressed; and so in this sense an individual's behaviour is clearly attention seeking. Such terms as the latter are, however, often used in a pejorative sense and may serve to legitimise a hostile response from staff towards the individual (Dextor and Towl, 1995:55).

Staff at Lovech prison in Bulgaria considered self-harming to have been less prominent in the last few years. Self-harm is perceived as a problem for the prisoner and also a problem for the medical staff as, during the care of this person, they have to ignore the chronically sick person. Additionally, it is expensive to treat, as the doctor has to take them to the community facilities for treatment.

Amongst the prisoners there is evidence of some cutting, swallowing and suicide attempts by swallowing disinfectant. Last year in Lovech prison there were 25 incidents of self-harm recorded. The prison records incidents of self-harm and yearly numbers are sent to the Department for Punishment Execution. The response to self-harm, according to the prison doctor, "is not very sympathetic but we don't let them die. In 95 per cent of cases the reason for self-harm is due to causes outside of the prison, for example social problems or problems with the judicial system".

At Varna prison, all new prisoners go onto a special induction section for one month. The psychologist immediately sees those who are dangerous or at risk of self-harming.

There has not been a case of suicide in the prison for a long time. There is not considered to be a lot of cases of self-harming but, when it does occur, it is usually amongst drug using prisoners and relates to problems with the courts rather than the prison itself. The self-harm is usually demonstrative and mostly cutting. There is usually a sympathetic response to self-harming from staff. As the head of security said:

they [prisoners who self-harm] often just want attention but some people do it as they think that they are innocent. We figure it out if it is a serious problem or not; for example drug users may do it as they want something. In the serious cases the response is not sympathetic but we act professionally then isolate them and call for the doctor if it is bad and then talk to them about not to do it in the future and we also call the psychologist. (Head of Security, Varna prison, June 2003)

The profile prepared at the time of induction in Czech prisons highlights prisoners who are seen to be at risk of self-harm. Staff in the sample prisons felt that although self-harm happened from time to time, it was not a widespread occurrence in their prisons. In addition prisoners are informed during the induction period:

that self-harm is forbidden in prison. Hence, harming oneself means breaching the regulations. Self-harm is thus not an issue in prison. (Specialist Staff, Opava prison 2003)

The incidence of self-harm in the Czech Republic has declined since the early 1990s. This is probably as a result of prison policy, where the psychologist and medical staff see prisoners at risk of self-harm or who do self-harm (MacDonald, 2003) rather than the prisoner believing it to be against prison regulations.

In Estonian prisons self-harm is considered to be a major problem and one that it is frequently used as a way to manipulate staff. The prison department commissioned a study by a group of psychiatrists about what the prison service should do about self-harm. The outcome of this study was the suggestion that there should be more psychiatrists in pre-trial prisons who should work with a team of psychologists. There are currently 150 cases of self-harming across the nine prisons in Estonia. There were four suicides last year in Estonian prisons.

In Viljandi prison there have been no suicides in the last ten years. Self-harm can be a problem, but is dependent on the nature of the prison population. None of the prisoners are self-harming at the moment. Self-harm usually occurs when prisoners first come into the prison as a reaction to the prison regime. The incidence of self-harm decreases as the prisoners settle down to prison life. If prisoners self-harm they will receive help but will also be punished. The doctor (Viljandi prison, 2003) considered that:

self-harm is not happening now because prisoners are punished for self-harming and put in isolation and this has solved the problem.

At Tartu prison self-harm is not a big issue but it has happened during the last six months as prisoners are adapting to this new style of prison. There have been 28 incidents in three months but it is now reducing. This has involved swallowing, cutting and hanging. There has been one suicide so far in the prison and this was by hanging. It is usually the male prisoners who self-harm. There is a sympathetic attitude towards self-harming and prisoners are given both medical care and psychological care. The prisoners are not punished for their actions.

More cases of self-harming were expected due to the change from a camp style to a cell type prison. Some prisoners are happy with the latter style of prison whilst others are not. There were applications to come here at first but when prisoners arrived they found that the controls were stricter and some have tried to go back to the camp style prisons.

Medication is strictly controlled and usually administered by the nurses. However, some less dangerous medicine is given to the guards to distribute. Where possible they crush pills and medicines are kept in the medical centre. Medicines are usually given under the control of the nurses but less dangerous medicine is given to the guards to distribute.

The prison doctor at Tartu reported that pre-trial prisoners suffer from adjustment problems and are more likely to self-harm. One prisoner said:

as a pre-trial prisoner it is possible to be here for several years and that is with two people maximum in the cell. This makes you mad and causes things like self-harm and suicide attempts. There is a lot of self-harm but this is not talked about publicly. We don't tell the guards and they may not find out as they don't check us very much. Here there is more of a punishing reaction rather than a sympathetic one. (focus group, Tartu prison 2003)

As can be seen from the quotation above, prisoners and staff had a difference of opinion about whether there was a sympathetic response to incidents of self-harm.

In Hungary, the number of incidents of self-harm in the prisons decreased during 2003. The Prison Department's policy requires that self-harm should not be punished 'but some directors do [punish self-harm] but for other reasons, such as if it is perceived as manipulative behaviour' (Prison Department, 2003). The suicide rate for all prisons has remained between 8 to 11 cases per year.

The low number of suicides (in comparison to other countries) in Hungarian prisons is thought to be related to prisoner culture. Prisoners generally do not approve of suicide (Heylmann, Prison Department 2003).

One member of staff interviewed at Budapest Central prison considered people who self-harmed were badly treated, as in Hungary every incident of self-harm is viewed as attempted suicide. In his opinion, self-harm and attempted suicide should be clearly differentiated:

prisoners have to fill in forms after they have self-harmed saying that they will not do it again! I have been working in prison for a long time and those who want to die, they don't tell anyone. Self-harming is more a cry for help or attention and in some cases manipulative to get a benefit. In this prison there is a lot of cutting [self-harming] amongst the prisoners. (Specialist Staff, Budapest Central prison 2003)

Ilguciema prison in Latvia has not had a suicide in the last nine years and very few cases of self-harm. As one member of staff commented:

self-harm doesn't happen very often but more so in some groups of prisoners than in others. We keep a list of vulnerable prisoners to see if it [the self-harm] is pathological or a one-off event. These prisoners are then monitored for 6 months. (Prison staff, Ilguciema prison 2003)

Prisoners in the focus group at Ilguciema prison, while confirming that self-harm was rare, thought that if they did self-harm they would be punished.

At Pārlielupes prison there was a suicide two or three years previously and a check is kept on prisoners who are considered to be a suicide risk. Self-harm was considered to be a rare event in the prison, with approximately eight cases in 2002. As one member of staff remarked:

self-harm rarely happens; if it happens it is usually manipulative behaviour. The response to self-harm is nothing special; we just deal with it and afterwards they [the prisoners] are punished, for example with 15 days in isolation. (Staff, Pārlielupes prison 2003)

During the first six months of 2003 there have been nine suicides in Lithuanian prisons (Semenaite, Correctional Affairs Department 2003). While there is not a specific suicide prevention strategy, all prisoners at reception to prison are seen by a team of specialists (including a psychiatrist) and if there are problems they will have consultations with medical staff or the psychiatrist. The Correctional Affairs Department are aware that there is a need for more psychologists to be employed in the prisons to play a role with suicide and self-harm prevention.

At Alytus Correction House, the assessment period at reception to the prison is used to inform the decision relating to the section in which to place new prisoners. If prisoners are sent to the prison hospital, they will go through this initial assessment period again upon their return. Self-harm was identified as a problem by a range of staff, the majority of whom perceived self-harming as manipulative behaviour used by prisoners to obtain improved conditions. The prison psychologist sees all prisoners who have self-harmed or who have attempted suicide. The response to self-harm is usually negative leading to punishment in some cases:

I talk to prisoners about their reasons for self-harming and most are manipulative. It depends on the case if they are punished or not and the decision is made by a commission [consisting of a range of specialist and security staff]. In the majority of cases they [prisoners] are trying to manipulate staff. (Specialist staff, Alytus Correction House, 2003)

Some staff identified a need for specialist training about self-harm and suicide prevention.

Kaunas Juvenile pre-trial prison and Correction House had previously been criticised as they had experienced a high number of self-harm incidents (153 cases in 2001). The number has now reduced. There was one suicide in the prison in 2002 and two attempted suicides this year (Director Kaunas Juvenile pre-trial prison and Correction House, 2003). Prisoners are more likely to self-harm in the pre-trial prison due to problems with adapting to prison life, conflict with other

prisoners and mental disorders (Specialist Staff and Prisoner, Alytus Correction House, 2003).

In previous research in Poland it was found that some prisons had a suicide prevention strategy whereby:

at the point of reception into the prison an assessment is made about a prisoner's risk of suicide. The prison suicide prevention strategy involves trying to identify those prisoners most at risk and how they will adapt to prison life. Those who need particular care are identified. If a prisoner is recognised as requiring psychological care they are put into a particular cell. (MacDonald, 2003:17)

In Sluzewiec prison during the last year there were no suicides and no incidents of self-harming had been reported.

In Montelupich prison there were no suicides in 2003 and one in 2002; there were 19 cases of self-harm in 2003. Self-harm was felt to occur as an expression of protest (an adaptation problem), because prisoners suffered from psychological problems or, as a means of attention seeking (Specialist staff, Montelupich prison 2003).

In Romania it is generally male prisoners who tend to self-harm and this is usually viewed as manipulative behaviour by prison staff (General Directorate of Penitentiaries, Bucharest 2004). Educators monitor signs of suicidal behaviour amongst prisoners and this is advanced as a reason for the low suicide rate. At Rahova prison there have been some cases of self-harm. Staff consider that for some prisoners it is a passing phase. For others having signs of self-harm can also give status.³³ Some prisoners learn to self-harm:

especially juveniles at the time of arrest while they are in police detention cells. After a while as prisoners come in and out of prison they learn more ways of self-harming. There are some prisoners who keep self-harming due to psychological problems. (Head of Health Care, Rahova prison 2004)

Prisoners from the focus group considered that:

the vast majority of prisoners who self-harm have psychological problems or they do it to change their conditions in the prison. This behaviour is normal in prisons. There is a certain art in doing self-harm in a way so as not to hurt yourself, for example banging a nail into your head. The way they do it is very precise so as not to do permanent damage. They know they can be punished for doing this and they know the risks but they still do it. (Prisoner focus group, Rahova prison 2004)

At Târgşor prison they experience two or three cases of self-harm each year but 'they are never serious, usually occurring due to arguments amongst prisoners, usually cutting and manipulative behaviour. We point out to the prisoner that they will get nothing as a result of self-harming themselves' (Specialist Staff, Târgşor prison 2004).

At Trenčín prison in Slovakia there have only been two suicides since 1999 and between 100–140 cases of self-harm every year during the period

33 Indicates that a prisoner is skilled, for example knowing where to place a nail in his forehead so as not to cause permanent damage.

1999–2002. In 2002 at Bratislava prison, three prisoners killed themselves. According to the head of health care at Bratislava pre-trial prison, the incidence of self-harming comes in phases. Following a self-harm incident, both the psychologist and psychiatrist keep the prisoner under a higher level of surveillance.

Ilava prison had 23 cases of self-harm in 2002. It was said that prisoners often use self-harm as a way to manipulate staff. Those who self-harm usually eat metallic objects and quite often refuse to eat. The response to prisoners who have self-harmed is to always talk to them and explain that self-harming makes their overall health worse (Head of Health Care, Ilava prison, 2004):

I know this [the prison] environment well and I meet the heads of the other departments every morning and I discuss the issue of self-harm and try to guide them about how to help the person who has self-harmed. (Head of Health Care, Ilava prison 2004).

In the juvenile prison they have eight to nine cases of self-harm each year. Juveniles were considered to be prone to self-harm because they have problems adapting to prison and there are some attempts at suicide and some prisoners who ‘cut themselves.’

The number of suicides in Slovenian prisons during 2003 was three. At Ljubljana prison suicide prevention is offered via counselling. There is about one suicide per year at the prison. Self-harm can be a periodic problem and is generally considered to be manipulative, for example, if a prisoner wants something. According to prisoners:

everything is centrally regulated by the prison, so they can’t really do much in response to you self-harming. If people cut their veins and stuff and have psychiatric problems, they sew you up and bring you back. (Prisoner focus group, Ljubljana prison 2003)

At Dob prison, suicide was rare, with about one case per year, whereas self-harming was more frequent and more likely with drug users during withdrawal or with prisoners who are depressed or are experiencing psychological difficulties.

Summary of common problems

The discussion in this chapter has shown that the prisons in the sample face a range of problems that impact on risk behaviour and prisoners’ health. In summary, prisoner hierarchy flourishes in rooms where there are a high number of prisoners sharing. Refurbishment in some prisons is reducing the number of prisoners sharing a room and this may have some impact on the hierarchy. However, all of the countries considered that budgetary constraints curtailed their ability to improve prison conditions. The majority of the countries, however, did have a refurbishment programme in place.

In addition, some prison services are dealing with prisoner hierarchy by deliberately isolating those people known to be leaders. However, in some of the sample prisons visited, staff considered that there was very little they could do about

bullying and sex amongst prisoners in large rooms at night, when the doors were locked and a limited amount of staff on duty.

Although in most prisons prisoners were advised at entry that bullying was not tolerated, there was not always a formal anti-bullying strategy in place. Further, not all prison staff interviewed were aware of the correct procedures for dealing with bullying. As mentioned above, many prisons were finding it difficult to provide opportunities for work, or other meaningful activities and this, coupled with overcrowded conditions, can lead to health problems:

the tedious prison environment – lack of occupation of mind and body and just plain boredom – leads to accumulated frustrations and tensions and to high-risk activities, such as use of drugs, sexual activities between men, tattooing and other “blood brotherhood” style activities. Some indulge in these activities to combat boredom. Others, however, are forced to engage in them, in a coercive play for power or monetary gain. Risky lifestyles can lead to the transmission of diseases from prisoner to prisoner, and pose a serious public health risk if unchecked. (World Health Organization-Europe “HIPP” (Health in Prisons Project), 2001:11)

Many of the prisons in the sample were experiencing an increase in problematic drug use in the prison population. While some prison systems were more willing than others to acknowledge that drugs were available in the prisons, staff in most of the sample prisons were aware that drugs were available in their prisons. In some prisons injecting drug use was occurring amongst some groups of prisoners. All of the prison systems were implementing procedures to reduce the amount of drugs that came into prison.

Testing for HIV was available to prisoners in the majority of the countries. However, HIV pre- and post-test counselling was not always available in the sample prisons. All the prisons considered hepatitis C to be an increasing problem among problematic drug-using prisoners.

As can be seen by the previous discussion, acts of self-harm are generally perceived as ‘manipulative’ and in some cases, prisoners are punished after self-harming. Punishing prisoners for self-harming is not best practice and is not in line with Council of Europe Recommendation Concerning the Ethical and Organisational Aspects of Health Care in Prison no. R (87) 7 that suggests ‘mental health services and social services attached to prisons should aim to provide help and advice for inmates and to strengthen their coping and adaptation skills’.³⁴

34 COUNCIL OF EUROPE, COMMITTEE OF MINISTERS RECOMMENDATION No. R (98) 7 footnote 1 OF THE COMMITTEE OF MINISTERS TO MEMBER STATES CONCERNING THE ETHICAL AND ORGANISATIONAL ASPECTS OF HEALTH CARE IN PRISON (*Adopted by the Committee of Ministers on 8 April 1998, at the 627th meeting of the Ministers’ Deputies*). No: D. 53. Mental health services and social services attached to prisons should aim to provide help and advice for inmates and to strengthen their coping and adaptation skills. These services should co-ordinate their activities, bearing in mind their respective tasks. Their professional independence should be ensured, with due regard to the specific conditions of the prison context.

Chapter 6

Health care provision in prison

A range of issues was identified by the research in the provision of health care. Key areas of concern were HIV/AIDS, tuberculosis (TB), sexually transmitted diseases (STDs) and hepatitis C. Other issues included the need for staff education and continuing education, budgetary shortages, confidentiality and equivalence of provision.

Structure of prison health care

In Bulgaria health care is free for prisoners and comes from the state budget. The prisoners do not have health insurance but their family can pay for prescriptions for more expensive medications; in fact usually the family have to do this (Doctor, Lovech prison, June 2003). All prisons in Bulgaria have a medical centre with a doctor, psychiatrist, dentist, assistant doctor and a nurse. New prisoners have an initial examination and during this examination staff determine who is a drug user. However, they do not use drug tests but ask prisoners if they use drugs. (Head of Health Care, Department for Punishment Execution, June 2003).

At Lovech prison the prison health care service includes specialists and GP services. One problem identified by the doctor was that it could be difficult to arrange to take prisoners to outside clinics because of the overcrowding and the need for an escort with security staff. There are different health care departments in the prison, one for respiratory diseases and one for psychiatry. The head of health care at Varna prison considered the facilities in the health care department could be improved; for example, her office was not suitable for psychiatric consultations.

A key problem identified from discussions at the General Directorate of the Prison Service in the Czech Republic was the recruitment of:

medical staff and GPs in prisons, as they often have no experience with drug users and do not like working with drug users. It is hard to hire GPs to work in prisons and we often end up hiring those who are capable of doing a GP's job, but who can't deal very well with drug users. (General Directorate of the Prison Service, 2003)

Some medical staff at Příbram prison agreed that there was a need for an increase in their numbers, especially due to the large amount of paper work that was required of them.

Health care for prisoners in Estonia is a part of the National Health Care System paid from the state budget through the Ministry of Justice.

In Hungary prison health care is considered to be very expensive and is provided by the Prison Department. The Hungarian National Health Service does not at this time want to provide prison health care (Prison Department, 2003).

In 2001 the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) made a number of recommendations for the Latvian prison system. Among these, the committee suggested that:

prison health care services should assume a more active role in monitoring living conditions in Latvian prisons and, if necessary, advocate appropriate measures with a view to promoting the health of prisoners. (CPT, 2001)

The head of health care at Alytus Correction House in Lithuania argued that if you asked prisoners who had been in the prison during Soviet times, they would say that the health care provision is much better now especially that it is a non-militarised service.

The Central Board of the Polish Prison Department includes fourteen hospitals providing 1344 hospital beds. The hospitals provide a wide range of medical specialities for example, HIV care, treatment of tuberculosis, dermatology and so on.

There are three main health programmes currently underway in Polish prisons and each is managed in collaboration with an external organisation. The 'Anti-virus treatment of HIV carriers in Poland' is organised in cooperation with the Ministry of Health, whilst the 'Health in Prison Project' is run in cooperation with the World Health Organisation.

In Romania Rahova prison hospital has been open for seven months (2003) and is very modern and well equipped. It will serve all prisons in Bucharest and also the police service for emergencies relating to individuals in police custody. The hospital has 113 beds and caters for male and female prisoners; there are no staff shortages and the facilities are considered to be better than those offered in the community. The hospital also has a detoxification unit with six beds and the medical staff, psychologist and psychiatrist are experts in the field of drug use. The treatment for problematic drug users in the hospital will last between two to three weeks. Although there have been no cases yet, the unit has been set up in preparation for future problems.

Rahova prison, situated in the same compound as the hospital, has its own separate health care centre and staff. Each section in the prison has a room for consultations with the doctor and each doctor covers two sections.

Prisoners at Târgșor prison had mixed views about the provision of health care in the prison. Some prisoners considered the health care provision to be very good while others were less satisfied. The women prisoners said that they did not want to be sent to Rahova hospital for a variety of reasons:

if we are sent to Rahova hospital we lose days [as during the period in hospital they can't work] from our sentence and we get searched and have to wear a uniform. We are transported in very miserable conditions just like animals. As we have to be kept separate from male prisoners it is very crowded. If we want to move we can only stand up and there is no ventilation as there is only a small vent in the van and the staff smoke a lot. On short journeys it is bearable but it is a real problem on long journeys. (Prisoners focus group, Târgșor prison 2004)

Prisoners in the focus group said that they did not complain because they felt this would make things worse. During the discussion prisoners said that this was a result of attitudes inherited from the Soviet regime that were only changing slowly. The prison health care department provides the opportunity for the prisoners to have a range of checkups but some prisoners refuse. The reasons given for this by the focus group were that:

- they didn't want to go to Rahova hospital for the reasons mentioned above;
- some women felt that in the mass screenings they lost control over their own bodies;
- some women were not able to talk about the results with the doctor who did the tests.

In addition, the women were upset at not being given any notice that they were going to the hospital:

it takes from Wednesday to Saturday to go to Rahova hospital and we are only told the night before going and you may be having visits and you can't tell them that you won't be here as we can't use the phone after a certain time so we can only send letters. (Prisoner focus group, Târgșor prison 2004)

Târgșor prison healthcare department has arranged for prisoners to have cervical and breast cancer screening from next year and finance for this has already been agreed.

In Slovakia prison health care is, legally, comparable with that provided in the community. Article 80 of the State Administration of Health Care governs the health care provided in both prisons and the community at large.

Prisoners in the focus group at Trenčín prison considered the doctors and access to specialists as good. They were less enthusiastic about the provision of dental care.

There are twelve health care units operating in the prisons in Slovenia that are staffed by full time nurses employed by the national prison administration. Medical doctors are employed and provided by the National Health System in the community. It is sometimes difficult to get doctors as they:

very often refuse to work in prisons. It is a difficult population and environment to work in. Moreover, prisoners have threatened doctors previously because they wanted to receive specific types of medication. (Head of Health Treatment, National Prison Administration 2003)

Specialised medical treatment is carried out in outside hospitals, as the national prison administration do not have a prison hospital and, as a result, there is a close working partnership with the Ministry of Health. All prisoners have the same health insurance as others in the community. Prisoners' health insurance is paid by the state.

Dob prison is the only prison in Slovenia that has a doctor paid by the Ministry of Justice. There is one GP, one assistant nurse (technical health officer), one psychiatrist (at the prison once a week), one nurse (and one post for another nurse, vacant since March 2003), and one dental nurse to cover the 380 prisoners.

These staff have to cover both the morning and evening shifts and were not considered to be enough to do this adequately:

we cannot be sick. The dental nurse has helped in cases of emergency, but she is not trained for it. There is a lot of paper work that the medical staff must do. There is a need for more vocational and physical therapy, as prisoners have nothing to do and stay in their cell and get stoned. According to the CPT Dob prison should have more nurses, of which some should have been trained in drugs and addiction. (Health Care staff, Dob prison 2003)

Access to health care

At Lovech prison in Bulgaria 24 hour and weekend medical care is provided. If a prisoner makes a request to see a doctor, it was said that he will be seen very quickly, sometimes after five to ten minutes. Prisoners in the focus group confirmed this was accurate. The prison also has a qualified dentist plus a full time dental nurse. Up until four years ago they could not find a dentist to work in the prison. The doctor thought that prisoners appeared happy with the dentist, who provides dental hygiene and false teeth.

At Varna prison all prisoners can sign up to see the doctor or dentist on three days of the week. On the other two days of the working week, the doctor sees only the prisoners with life sentences. Prisoners will usually wait for about 24 hours to see the doctor. If there is an emergency, the doctor is on call all the time. Prisoners in the focus group said that the medical care that they received was usually restricted to painkillers. The prison also has a dentist who provides a limited service (taking teeth out) but prisoners, if they have money, can pay for other dental services.

The medical cover at Varna prison is neither 24 hour nor available at weekends. Prisoners who are chronically sick are given their medication for three days at one time and it is always a trained person who dispenses the medication. The doctor considered it to be important that prisoners were responsible for taking their own medication. The lack of 24 hour medical cover was perceived to be a problem by some staff. The head of security felt that it would be helpful:

if we had a doctor here all the time as at weekends the doctor leaves the medicines for prisoners here with us to distribute. It is not easy for us to do this as we don't have the medical training. Prisoners take their medication and if there is a crisis it is not really our job to deal with this so they do need more doctors here. (Head of Security, Varna prison, June 2002)

In the Czech Republic all prisons have their own medical centre and there should be one doctor and three nurses for every 500 prisoners.

Opava prison has a medical department with one full time doctor, one part time doctor, five nurses and some specialists who have a contract with the prison. The medical provision is from 06.00 to 14.30. If there is an emergency, the prisoner can be escorted to the hospital in the community. At Příbram prison the medical department has two full time doctors and six nurses and operates from

0600 to 14.30. Over the weekend and at night if there is a need, prisoners can be taken to the hospital by security staff.

Prisoners who wish to see the doctor at Opava prison must sign up the night before or on the morning of the day they want to see the doctor. However, these regulations are relaxed in the event of an emergency. Prisoners from the focus group at Opava prison were critical of the health care provided by the prison:

- the doctor here is really old like a pensioner. If you go and tell him that you have a headache he sends you to play tennis instead. If you go and tell him you need some soda because you have heartburn, he says no, you just eat too much, you should eat less and use less spices.
- I went to the doctor this morning actually, because I have got problems with my teeth; I went just to get some pills to kill the pain. The doctor sent me outside to go and run around, but that didn't help!
- Just a little while ago I almost passed out in the hallway due to the pain and the doctor doesn't want to prescribe the drugs that are written in my medical file. There is an attitude here that you were taking drugs, you're used to taking drugs, you're used to the pain of going through withdrawal, every problem I have they blame it on the drug use. Every time I go to the doctor, he says that's because you were taking drugs and doesn't prescribe any medicine for me.

In Estonia there was a strong contrast between the two prisons in the facilities available to the health care departments. Viljandi prison health care department is currently being painted and decorated and, when this is completed, it will be greatly improved. The health care department in Tartu prison, in contrast, was very modern and well equipped.

In Viljandi prison access to the doctor is immediate due to the small prison population. In Tartu prison prisoners wait one week (unless it is an emergency) to see the doctor. In Viljandi prison, during Soviet times, there used to be 24-hour medical cover but now it is only provided between 8 a.m. and 8 p.m. when the doctor is in the prison. At any other time an ambulance can be called.

In the larger prisons in Hungary there is 24-hour cover by nursing staff and in smaller prisons nurses and doctors work office hours.

At Baracska National Prison the doctors work eight hours per day and at weekends they are on call. The nurses are available 24 hours per day. If there is an emergency, a prisoner will be seen immediately. Surgeries are normally held three times per week, from Wednesday to Friday. A prisoner will be seen on one of these days depending on the regime that the prisoner is on. Prisoners sign up to see the doctor and will normally be seen on the next appropriate day.

The prisoners from the focus group at Budapest Central prison were unhappy with the medical service that they received:

I am very angry with [access to see a doctor] and would like to change the system. We can see the doctor on a Wednesday and Friday but we have to wait a long time if we have a headache on Monday. You get the same medicine for all complaints. I have diabetes and I don't feel it is managed well here in the prison. (Prisoner focus group, Budapest prison 2003)

In Ilguciema prison in Latvia, medical care is available between 8 am and 8 pm and, if required, an ambulance can be called outside these hours. There is also a nurse on duty 24-hours a day in the mother and child section of the prison. After making an application to see the doctor it takes, at maximum, one week before a prisoner will be seen.

At Pārlielupes prison, 24-hour medical cover is not provided but, if there is an emergency, an ambulance can be called. The medical department is open 8 am till 4 pm Monday to Saturday, but it is not open on Sundays or public holidays. There is a nurse on duty in the prison on Sundays. Prisoners can see the doctor on the same day that they make the application, depending on their individual regime, as there are defined times for activities for each section in the prison. Prisoners in the focus group were not always happy with the medical service provided:

the dentist is never available and we wait a long time to see him and end up treating ourselves. When you are on the first level regime it is difficult to see the doctor as you need to write several applications. (Prisoners, Pārlielupes prison, 2003)

In the focus group there were a number of HIV-positive prisoners who complained about the lack of care they had received. They reported that they were not being monitored for the progress of their HIV and that they received little information about the current state of their health.

In Lithuania at Kaunas Juvenile pre-trial prison and Correction House, health care is provided 24-hours per day. The doctor normally sees prisoners on the same day as the request for an appointment is made. The medical division belongs to the Correctional Affairs Department but is subject to Ministry of Health regulations. The requirements of the Ministry of Health are high and the prison medical division has limited equipment so, at times, it can be difficult to meet the standards required. However, the medical division does have access to a range of specialist physicians.

If the juveniles require hospital treatment they go to the local hospitals, as the prison service hospital is not licensed to treat juveniles. However, it is the Juvenile pre-trial prison and Correction House's aim to solve as many of the prisoners' health care needs as possible within the prison.

At Alytus Correction House the doctors are available during the day, whilst paramedics and GPs provide health care cover during the evenings, nights and weekends. The doctors are also on call during these times and, if there is an emergency, an ambulance will be called. A prisoner will usually see a doctor on the same day as the request is made depending on the time of day when the request is made.

In Montelupich prison in Poland, there is a 24-hour medical service available due to the prison hospital being located in the grounds of the prison. At Sluzewiec prison, health care services are available in normal working hours. However, there is no medical department in the prison and doctors are employed on a part time basis from the community.

In Romania at Rahova prison, there is 24-hour care provided, with doctors in the prison until 7 pm and, after this time, nurses are available. If there is an emer-

gency, an ambulance will be called. If prisoners request to see a doctor, they will normally be seen on the same day.

Târgșor prison also provides 24-hour medical cover. The prison has two doctors and eight nurses. At weekends both the nurses and the doctors are on call. Prisoners are considered to have good access to the doctor who they can usually see on the day that they make the request (Head of Health Care, Târgșor prison 2004). Prisoners in the focus group reported that they have scheduled days on each section when they can see the doctor and on that day they are able to make an appointment.

In Slovakia prisons have medical cover from 7.00 am till 3.00 pm each day. After this time, if required, an ambulance will be called. Nurses prepare the medicines that need to be administered to prisoners out of working hours, for the security staff to give to prisoners. At Trenčín prison access to the doctor is immediate if there are acute problems but prisoners usually sign up to see the doctor in the evening and go the next morning.

In Slovenia at Ljubljana prison health care staff thought that there were not enough nurses in the prison to deal with the number of prisoners coming in. A lot of the prisoners only stay in the prison for a few days:

but these prisoners still need to have a medical examination upon admission. Often these people are in a bad state and are under-privileged and don't visit the doctor outside. A lot of them have alcohol problems. (Nurse, Ljubljana prison 2003)

Prisoners from the focus group were not enthusiastic about the provision of health care:

We don't have a medical support here, like doctors. If you want to go to the psychiatrist, they listen to you, but they don't have that much time. You wait for months to see a dentist. (Prisoner focus group, Ljubljana prison 2003)

Confidentiality

Crucial to the patient-doctor relationship is keeping prisoners' health information confidential. It is important that prisoners are able to rely on health care staff not to disclose information about their health status. This is in accordance with the Council of Europe's prison health care rules 'the Ethical and Organisational Aspects of Health Care in Prison (Recommendation R (98) 7)³⁵.

Maintaining confidentiality is particularly difficult in the prison setting. Prisons are closed societies and prisoners and non-healthcare staff may guess something about a patient's health from observing the professional staff that they see, or which drugs they take. This makes it doubly important that health care workers and other prison staff, are vigilant in safeguarding prisoners' confi-

35 The Council of Europe Committee of Ministers, Recommendation No. R (98) of the Committee of Ministers to member states Concerning the Ethical Organisational Aspects of Health Care in Prison No. 13. Medical confidentiality should be guaranteed and respected with the same rigour as in the population as a whole.

ality. It is also important that they are seen by prisoners to be doing so. The importance of confidentiality cannot be over-stressed regarding medical information and in particular prisoners HIV status where:

the consequences of unauthorized disclosure in the prison setting can be extreme, including verbal abuse, stigma, discrimination in medical and other decision-making and treatment, threats of and actual physical violence, and in some cases even death. Prison staff who breach the duty of confidentiality owed to prisoners breach prisoners' right to privacy. The WHO Guidelines state that "information on the health status and medical treatment of prisoners is confidential" and can only be disclosed by medical staff with the prisoner's consent or where "warranted to ensure the safety and well-being of prisoners and staff, applying to the disclosure the same principles as generally applied in the community" [WHO Guidelines 31, 32]. (Canadian HIV/AIDS Legal Network, 2004:25)

The sample prisons in the ten countries under consideration achieved prisoner confidentiality to varying degrees. In Bulgaria neither of the sample prisons identified confidentiality as an issue nor considered it to be important. The director of Lovech prison didn't see that the issue of confidentiality was really a problem as the prisoners trust the health care department to help them with conditions like syphilis, hepatitis and TB. The issue of confidentiality was also mentioned by the CPT report involving Lovech prison in relation to who should have access to prisoners' medical reports. The prison director believes that there shouldn't be confidentiality. His reason is that a lot of prisoners appeal their sentence on medical grounds and the medical committee has to see their medical notes in order to be able to decide if the prisoner has a case. At Lovech prison a copy of the prisoner's medical notes is put in their prison record. This is done because at release prisoners are given their medical records to enable them to register with a GP. If a prisoner comes back to the prison a copy of his medical records will be available in the prison archives.

At Varna prison security staff are informed about which prisoners have hepatitis. However, the head of security advised that they were not informed who was HIV-positive as this was confidential information.

Staff at both sample prisons in the Czech Republic said that the information the nurses and doctors have about prisoners remains confidential. If there is a need to provide information about a prisoner, the prisoner must agree in writing before confidential information can be released.

In both prisons in Estonia staff were confident that they did not breach prisoners' confidentiality. In the juvenile prison only the medical staff know who is HIV-positive and such prisoners are not separated from the other prisoners. However, in reality, HIV-positive prisoners are likely to inform the other prisoners of their condition. A lot of preparatory work has been undertaken with prisoners to encourage them to accept those who are HIV-positive and, generally, those who are HIV-positive are tolerated. All prisoners are asked on arrival at the prison if they are HIV-positive and:

in the prisoners' sub culture the prisoners have to tell the other prisoners if they are HIV-positive and then they are treated OK. (Psychologist, Juvenile prison: 2003)

The prisoners in the focus group confirmed that they knew who was HIV-positive and that, on the whole, they tolerated them. However, they were not sure of being safe from infection: "staff have told us that we can't get infected but we feel there is still a chance".

The situation regarding confidentiality was somewhat different in Tartu prison as the number of staff who knew a prisoner's HIV status was limited. For example, prison psychologists do not see prisoners' medical notes. It was decided by the prison management that it was not really necessary for them to see prisoners' files but they can ask the social workers who have access to prisoners' files, for the information that they require. In this prison prisoners do not disclose their HIV status unless they want to, as confidentiality is better given the weakening of the prisoner hierarchy.

In the sample prisons in Hungary confidentiality was not raised as an issue by prisoners or staff. A recently introduced policy to no longer test all prisoners for HIV, or to segregate prisoners who are HIV-positive, has improved prisoners' confidentiality.

In theory, information about prisoners' HIV status in Latvian prisons is confidential. Information can only be given to the courts if the prisoner agrees. As the deputy director of one of the prisons said:

if prisoners want to apply to the court giving their HIV status, they can do this using a closed envelope. However, the prison censor checks all prisoners' letters apart from those in closed envelopes to official bodies. (Prison staff, Pärlielupes prison)

However, the director, the head of security, and the heads of units in Pärlielupes prison did know which prisoners were HIV-positive. Prisoners also acknowledged the lack of confidentiality in relation to HIV:

there is no anonymity in the prison; we have to tell the other prisoners and we think that all the staff know as well. It is not possible not to tell others as they need to know not to use our razors and so on. (Prisoner, Pärlielupes prison 2003)

This social pressure for HIV-positive prisoners to tell other prisoners about their HIV status can be linked to the prisoner hierarchy: prisoners who fail to tell other prisoners of their HIV-positive status could face reprisals if found out. Some staff argued that other prisoners accept those who are HIV-positive as long as they know. As one of the unit chiefs confirmed:

if a prisoner has lied about being HIV-positive and the other prisoners find out later he is in trouble; if he says he is HIV-positive then it is OK. So on the whole there is not a problem for HIV-positive prisoners. (Staff, Pärlielupes prison 2003)

In Lithuania prisoners' confidentiality is guaranteed by two legal Acts from the Ministry of Health (Semenaite, Correctional Affairs Department 2003). However, it is difficult to control confidential information amongst prisoners themselves. In the prison it should only be a limited number of staff that know, for example, whether a prisoner is HIV-positive. The staff who are informed are the prison director and the chief officer of the section where the prisoner is located. However, the director of Alytus Correction House said that the director is not informed of prisoners' HIV status.

The head of health care at Kaunas Juvenile pre-trial prison and Correction House said that it is difficult to maintain prisoners' confidentiality but they try to do so, for example by noting a prisoner's HIV status by using a code. The prison has had very few HIV-positive prisoners so far.

Confidentiality was not raised as an issue by either prisoners or staff in the Polish sample prisons. There are some times when HIV-positive prisoners inform other prisoners about their HIV-positive status. Confidentiality is governed by legal regulations that permit only medical staff to know about prisoners' health procedures. There have been no registered complaints or negative feedback from prisoners about a lack of confidentiality.

The prison staff have been trained about the regulations governing confidentiality based on UNAIDS and WHO guidelines. If a prisoner is HIV-positive, this is only recorded on the medical file. The prison director is only informed of prisoners' HIV status if a request is made to transfer individuals, for example, nearer to their family. The prisoners themselves usually break confidentiality but some staff also break it because the concept is still new to them, especially in the area of HIV (General Directorate of Penitentiaries, 2004). This was demonstrated during a conversation with medical staff who, when asked if the security staff were well informed about risk behaviour, responded:

yes and they also know who is positive in the prison. If a prisoner is HIV-positive then theoretically only the medical staff should know but I feel those in the same cell should know and the staff. If the prisoner said he didn't want it known then I would keep the confidentiality.

At Rahova prison the director knew which prisoners were HIV-positive. Currently, most prisoners are not very supportive to those who are HIV-positive (Prison staff, 2004) and this underlines the need for confidentiality.

At Târgșor prison only the medical staff know which prisoners are HIV-positive and the prison director is not usually informed. He is told only 'if the person with HIV is perceived to involve a "security issue"'. (Medical Staff, 2004)

In Slovakia prisoners' medical records are sealed during transfer between prisons and only the medical staff can read them. The prison director should not, according to the regulations, be informed about prisoners who are HIV-positive or hepatitis positive.

Confidentiality was not considered to be a problem in the sample prisons in Slovenia. In the case of HIV it was considered to be prisoners who would inform others of their status.

Equivalence

Prisoners have particular health needs and, as a whole population, experience many of the adverse social and environmental determinants of health. Several international conventions guarantee the welfare of prisoners. Prisoners lose their liberty but retain the right to protection from harm and access to a standard of health care equivalent to that provided in the community:

“equivalence” rather than “equity” has been called for because a prison is a closed institution with a custodial role that does not always allow for the same provision of care available outside. On the other hand, because prisoners are more likely to already be in a bad state of health when they enter prison, and the unfavourable conditions therein make the health situation even worse, the need for health care and treatments will often be greater in a prison than in an outside community. However, providing even basic health care to prisoners has proved extremely difficult in countries where the overall health systems have collapsed or are chronically insufficient. (World Health Organization-Europe “HIPPP” (Health in Prisons Project), 2001:12)

Overall, prison staff and the majority of prisoners in the focus groups felt that provision of health care in prison was equivalent to that provided in the community.

Staff at the Department for Punishment Execution in Bulgaria considered prison health care to be equivalent to that in the community and said that currently it can be considered to be better due to changes in the community system of health care. At Lovech prison the doctor considered the prison health care to be better in certain respects than that offered in the community. The doctor thought that usually they had what was needed in terms of equipment and medicines but that there were budget shortages sometimes. In an attempt to stop prisoners selling their medication, the chronically sick are given their medication directly by health care staff.

At Varna prison health care is considered to be better than that in the community as prisoners have less time to wait for treatment in the prison than they would in the community. Regarding medicines the prison health care department are fairly well off compared to the situation across the country and all treatment and medicines are free for prisoners. Every week there are medical specialists coming to the prison and prisoners can also be placed in an outside hospital.

Providing an equivalent health care service can be difficult according to the General Directorate of the Czech Republic Prison Service, as they have problems finding doctors to work in prisons:

young doctors need experience first from outside. Working at the prison is suitable for doctors with experience but requires a lot of work, long hours, working over weekend and stress. As to Opava prison, there are neither doctors nor nurses at the prison over the weekend. An ambulance can be called and the prisoner is either treated in prison or in hospital. (Doctor, Opava hospital 2003)

While it is argued by the prison service that health care in prison is equivalent to that in the community, the problem of finding doctors to work in prisons and the lack of health care staff in some prisons over the weekends and during the evenings raises questions concerning the possibility of providing an equivalent service.

In Estonia the medical staff at Tartu prison considered the provision of health care to be equivalent to that provided in the community and the department is well equipped. The doctor at Viljandi prison felt that more equipment was needed and he was concerned that there will be problems in the future dealing with HIV-positive prisoners when they become ill. Two prisoners from the adult prison said that:

it takes a few weeks to get to see the doctor, and the psychologist a few months. It takes an even longer time to see the dentist; then you have to pay for the treatment. My cellmate wanted to see a specialist and it took almost one month. (Prisoner focus group, Tartu prison, May 2003)

The doctor at the juvenile prison said that the prisoners were experiencing problems with their teeth and 15 prisoners were currently on the waiting list for dental care. To add to the problem, there was not a prison dentist nor was it possible to recruit one at the moment. The reason given for this was that dentists don't want to work in the prison. This lack of dentists is a common problem across the Estonian prison system. One reason for this is that dentists are highly paid in the community. A previous dentist at Tartu prison provided only a limited service to prisoners. The Health Care Adviser from the prison department said that all Estonians in the community have to pay for dental care and prisoners have to do the same. In prisons where it is not possible to employ a dentist for the prison, prisoners will be taken to a dentist in the local community.

Overall both prisoners in the focus group and the medical staff from the sample prisons in Hungary considered the prison health care to be equivalent to that offered in the community.

In Latvia staff at Ilguciema prison felt that even though they were short of money, the health care they provided was equivalent to that in the community. However, they pointed out that the budget was not enough for all the equipment or drugs that they needed. It is also possible to send women to the local hospital and to arrange for specialists. There used to be a problem with maternity care but using the city hospital has solved this.

There was considered to be adequate medicine and equipment at Pärlielupes prison and if specialist care was needed prisoners were sent to the prison hospital. The prison also provides dental and optical care.

In Lithuania the opinion of the majority of prison staff was that health care provision in prison was currently better than provision in the community. A key problem is that prisoners very often do not have health insurance and after release from prison it is difficult for them to have continuity of care (Director General, Correctional Affairs Department 2003).

Each prison receives a medical budget but all medicines are decided and purchased centrally as this is considered the most economical way to provide them.

The current budget for medicines is not considered to be enough but it is better than it was previously.

At Kaunas Juvenile pre-trial prison and Correction House there was considered to be a lack of equipment and some of the equipment they do have is old, which makes it harder to provide equivalent services to those in the community, especially in relation to legislation on children's rights. The medical division has enough medicines at the moment but could have problems in the future if they had a seriously ill patient requiring expensive medication. The medical division would like to have more psychologists and increased funding to improve staff expertise on drug use, communicable diseases and mental health.

The head of health care at Alytus Correction House felt that health care was sometimes better in the prison: for example as a psychiatrist he had more time in the prison to talk with patients than he had in the community setting. The budget for health care was considered to be adequate, but did not allow for such things as vitamins for HIV-positive prisoners or for urine testing confirming that prisoners were 'legally' drug users. Some of the equipment in the medical division was considered to be old but they will be getting some new equipment in the near future.

Health care provided in the prisons in Poland should be equivalent to that provided in the community:

Article 115 of the Penal Executive code states that sentenced prisoners shall receive free medical care, free provision of medications and dressings and, in particularly justified cases, free dentures. There are said to be good co-operative relations between the prison health care service and the Ministry of Health. Urgent consultations, surgical interventions and specialised medical procedures are provided by the public health service and paid for from the prison health care budget. (Walmsley, 2003:400)

Health care in prisons is considered to be better than in the community especially the waiting time for specialised treatment and testing procedures. Prisoners are the only social group for which the whole spectrum of health services is financed by the state budget (including pharmaceuticals). There are difficulties in recruitment of doctors due to a negative public opinion about working in prison especially in small towns and villages. However, there are no problems with recruiting nurses.

Staff at both Rahova and Târgşor prisons in Romania considered the health care provided in prison to be better than that in the community although both prisons said they would also like more staff, for example Rahova prison had a vacancy for a doctor medicines and equipment. The head of health care at Târgşor prison said that the prison had good cooperation both with the hospital at Rahova and community health services near the prison.

The majority of prison staff in Slovakia considered the health care provided for prisoners to be equivalent to that provided in the community. However, one member of the health care staff claimed that there is still discrimination against prisoners.

At the current time, according to the Slovenian prison administration, the provision of health care in prison is seen as an area where a lot needs to be achieved. The main problems are caused by a lack of finances that is restricting the imple-

mentation of the changes required (Joze Hren, Government Office for Drugs, 2003). One such problem is the common practice of security staff delivering medication, including methadone, to prisoners.

At Ljubljana prison if a prisoner needs to see a doctor over the weekend, he/she has to wait until the Monday because doctors work on a contractual basis. This raises the question about what services are provided for problematic drug users who arrive at the prison on a Friday evening and who makes the decision as to whether they require help or not. Prisoners who have serious problems at the weekend will be taken to the local hospital.

At Dob prison during the week the doctor and nurse deliver the methadone, whereas during the weekend the head of security dispenses the methadone. Staff in the prison did not think that this practice caused problems with prisoner confidentiality. It was necessary to do this due to the shortage of medical staff. In addition, security staff deliver prisoners (general, psychiatric) medication, prepared in advance by medical staff and clearly labelled, three times a day.

At Ljubljana prison the health care unit prepares the medication and security staff give it to the prisoners:

prisoners tend to ask guards for higher doses but it is the doctor who decides on the dose. If there is a crisis with a prisoner, then he is taken to the hospital. Methadone is an additional task that the guards must do but this does not provide any extra stress, apart from the fact that guards must be careful that the doses are not stolen. (Head of Security, Ljubljana prison 2003)

This practice occurs due to the lack of medical personnel and it is also the view of the prison administration that this does not cause concerns for security staff.

Cleanliness, hygiene and food

Cleanliness and hygiene are two factors that impact on the potential health of prisoners where:

the adequacy of sanitary arrangements is recognised to be fundamental to the question whether prisoners are treated in conditions that ensure respect for human dignity, as required by Rule 1 of the European Prison Rules. (Walmsley, 2003:29)

At Lovech prison in Bulgaria there are rooms from 2 to 20 prisoners. The prisoners are locked up from 10 p.m. till 6 a.m. and the rest of the time they are free to move about the sections and to attend clubs etc. There are 80 prisoners per section and one guard. There are no toilet facilities in the cells and the prison director said that he has been trying to get a project to change this for the last 10 years. Toilets are available in the hallways. Life sentence and high security prisoners are locked up all the time and are in one or two person cells.

The doctor at Lovech prison felt that in the area of prison hygiene there is nothing that the personnel can change as it is the standard of the prison buildings that is the major problem. He has to insist that prisoners respect hygiene stan-

dards but this doesn't always work as some prisoners have a low culture of hygiene and have fleas and skin diseases. In the cells prisoners can wash themselves and there are toilets available on the landings. The prisoners, however, use a bucket during the night in the cells. Prisoners can shower once per week but those working can shower every day. The showers are standard and separated from each other. There are some new bathrooms in some of the sections.

The prisoners from the focus group at Troyan Prison were dissatisfied with the prison conditions:

the rooms are very small and really miserable with 34 people in them. Sometimes one or two sharing a bed [this was not confirmed by the prison administration]. There are poor hygiene conditions where we have to use a bucket during the night. After 8.30 p.m. we are not able to leave the room until 6 a.m. We can shower once per week and we heat the water in buckets. The water is not always clean. There are 3 sinks for 50 people on the section. (Prisoner focus group, Troyan prison, June 2003)

The doctor at Varna prison thought the hygiene conditions were normal and prisoners can wash their clothes and shower once per week. There is no water available in the cells, only on the sections. There are no toilets in the rooms so a bucket has to be used. There are double bunks in the cells and currently these are overcrowded. The social worker said that prisoners' ability to have hot showers depended on money: if the prison has money, they can shower once per week; if not once per fortnight. They can wash everyday with cold water. Prisoners can also have cold-water showers at anytime. The prisoners in the focus group were very unhappy with the conditions in the prison:

some of us are in a 15 bed room with no toilet facilities and we have to use a bucket. We can only shower twice per month and we sometimes warm up water to wash with. We do this by making electric elements to heat the water and this blows the electricity and we get punished for doing it. There are 8 showers for 120 prisoners and the hot water doesn't always last. The prison provides soap but it is not very good and toilet paper is not supplied. (Prisoner focus group, Varna prison, June 2003)

The doctor in the prisons has the responsibility for the hygiene of the prison, kitchen, food quantity and quality. Prisoners in the focus group from Troyan prison said that the food used to be worse and that it is better now. They don't get fruit very often but they occasionally have watermelon and they do get salad with their meals. They can have fruit sent in packages from their families.

The doctor at Varna prison samples the food every day and samples of each meal are kept for 48 hours in case there are any problems. Prisoners have fruit or vegetables once or twice per week and usually have more fruit and vegetables during the winter. There are also special diets available for vegetarians and diabetics. Prisoners from the focus group considered the food to be:

not very good and there is not very much of it and we have the same things all the time. Sometimes the milk is spoiled and sometimes it is OK. (Prisoner focus group, Varna prison, June 2003)

In the juvenile section at Opava prison in the Czech Republic, there are a maximum of five prisoners per room with a sink and toilet in each room. The rooms are open during the day and the juveniles attend school and a range of other activities. In the women's section, life sentence women have a single room, otherwise there are two or three women per room. There is a sink and a toilet in each room. On each floor there is a kitchen, common room, smoking room and a cultural room with a television. The women are unlocked during the day. At Opava prison the prisoners can shower twice per week at specified times and after sports activities. However prisoners in the focus group said:

there are four showers for thirty people, so it gives you only about ten minutes to actually take your shower. But we have been told that the consumption of hot water has increased too much and by Monday they are going to cut off the hot water and we will have to use the kettle to boil hot water to wash with. (Prisoner focus group, male prisoners 2003)

Two key issues identified by medical staff at Viljandi prison in Estonia were HIV and skin infections (e.g. scabies). Skin infections are not as bad as they were in the past as hygiene is considered to be much better in the prison now. Prisoners have cold water in their rooms but no toilet or showers. They can shower once per week. Prisoners from the focus group who were in the drug section felt that "the living conditions on the unit are much better and cleaner than in the rest of the prison."

In Tartu prison sentenced prisoners can shower every day and pre-trial prisoners twice per week. The pre-trial prisoners have showers in their cells and hot water is available twice per week.

The medical personnel in Estonian prisons check the ingredients and taste the food every day and they also make spot checks. In both sample prisons the staff eat the same food as is provided for the prisoners. Prisoners at the Viljandi prison said "the food here is good and the best in all Estonian prisons. It is very rare to get fruit except for the occasional apple". In Tartu prison the doctor considered the food to be nutritious but the taste was not that good. Salads are available and vegetables more often than fruit.

The regulations regarding showering in Hungarian prisons are that prisoners who work can shower every day and those who are not working can shower twice per week.

On one of the sections visited at Budapest Central prison there were 140 prisoners and three showers available. The conditions at Baracska National prison were variable with some older buildings dating from the 1970s having only two toilets and one washbasin for 40 prisoners. In comparison, there are also some more modern buildings with better facilities. For example, there is one good building where the most dangerous prisoners are housed (despite being 200 per cent overcrowded) that has the best conditions with a grassed area for exercise. According to the prison doctor:

the prison tries to meet all the requirements [for hygiene] but this is not always possible. I don't like the three bunk arrangement in the cells. In the majority of buildings the situation is ok as the showers have been refurbished but some have been vandalised. It is positive that there are more closed exer-

cise areas for prisoners and body building rooms. (Doctor, Baracska National prison 2003)

The Hungarian Ministry of Health sets the norms for the calories required for prisoners to work and the prisons apply these standards. Prisoners from the focus group at Budapest Central prison said they didn't like the prison food but that it had improved a bit and they had fruit once a week.

In Latvia the conditions in Ilguciema prison were variable. Pre-trial prisoners are in rooms of four, six or eight people. The prison has a special mother and baby unit and each mother and child have a room to themselves. The standard of the unit was good, being modern, bright and clean and one part is being refurbished. There are special staff who run the children's unit, with a nurse on duty who provides 24-hour cover. The prison also has a separate section for juvenile prisoners. The unit has been refurbished and usually four prisoners share a room. The showers are of good standard and there is hot water provided three times per week. There are toilets in the separate cells; otherwise they are on the corridor. There is hot water in the rooms that have been renovated. Prisoners from the focus group said:

we can shower once per week with hot water but two of us have to shower together in a cubicle or the water runs out. We can have cold showers anytime in the summer. (Prisoner focus group, Ilguciema prison 2003)

Living conditions in Pārlielupes prison depend on the section. Some rooms are for eight people and in one of the rooms the window was very small and high up and prisoners said that there was very little ventilation. The conditions for pre-trial prisoners are the worst. They are able to be outside for three hours per day. There is TV in the rooms but the electricity is turned off between 10am and 3 pm. Prisoners commented that there was nothing to do but sleep, as there are very few jobs available in the prison. At Pārlielupes prisoners can shower once per week, according to the schedule for the section. In addition, prisoners should go to the sauna once per week. The prisoners in the focus group thought that:

it would be good to improve the sanitary conditions in the prison, to make the showers and sauna better as they are terrible at the moment. There is one shower for two units of 120 people and there are only eight showers. (Prisoners, Pārlielupes prison 2003)

According to staff at Ilguciema prison, the food is of reasonable quality. However, the prisoners get the same menu every week and salad every day. Fruit is not available as it is not grown locally and is very expensive. The children in the mother and baby unit get fruit and there is also a special diet for the young prisoners and pregnant women. The prisoners can buy fruit from the prison shop. Prisoners in the focus group felt that:

the food is not bad but you lack vitamins and we have the same menu every week; it would be better to have some fruit but it is expensive and we can't afford to buy it. We don't get any liquids with our lunch and we would like to have something. (Prisoners, Ilguciema prison 2003)

At Pärlielupes prison both staff and prisoners thought that the food did not taste particularly good and that there was not much of it. The prisoners are given tea with each of their three meals.

At Kaunas Juvenile pre-trial prison and Correction House in Lithuania, the prisoners can have a bath each week and are also able to take showers in the sports hall. The prison is in the process of refurbishing the rooms for prisoners and these rooms will house five prisoners each.

In Alytus Correction House, each section has showering facilities and once per week hot water is available. The showers in some sections are in need of renovation. Prisoners are able to heat water for their personal use and are able to wash their clothes, as a washing machine is available on each section. Prisoners live in dormitories of between twelve and sixteen people and some of the rooms are in need of refurbishment.

At Kaunas Juvenile pre-trial prison and Correction House new regulations regarding food mean that prisoners have four meals per day. The food in the prison is prepared by a professional cook rather than by the prisoners. From 2000 all prisons and correction houses have the same menu and the juveniles have bigger portions. The food is varied and the menu is set on a monthly cycle. Prisoners from the focus group agreed the food was acceptable, that it had improved and the portions were usually enough. The food was considered to be good and nutritious at Alytus Correction House with increased amounts of fruit. Prisoners from the focus group thought that the food now tastes better but that there was not enough of it and that it was low in calories.

Prisoners from the focus group at Sluzewiec prison in Poland said that they were not satisfied with the hygiene in the prison. Hot and cold water were not always available. Basic equipment provided by the prison such as toothbrushes, soap and toilet paper were considered to be of poor quality. Prisoners were allowed a shower twice a week, which they noted was better than the regulations of once a week.

At Montelupich, prisoners said that the quality of hygiene depended on the unit in which they were housed. They reported that the general facilities provided' such as toothbrushes and toilet paper were decreasing and that showers were only available once a week and only for ten minutes.

The food provided for prisoners is considered to be of comparable quality to that provided in communal catering in the community:

more is spent on food for prisoners than for patients in an outside hospital. The chief prison doctor said she would like to reduce the amount of fat in the diet that is provided. Although the legislation prescribes that staff and prisoners must be fed separately, staff and prisoners receive the same food, for example in Kraków prison. (Walmsley, 2003:400)

Prisoners in the focus groups at both sample prisons said that the quality of food in prison needed improving. At Sluzewiec prison, prisoners noted that not only should the food be of better quality but there should be more of it as well.

The prison regulations in Romania state that those prisoners who are working can shower every day and those not working can shower once per week. Women prisoners are able to shower more often (General Directorate of Penitentiaries,

2004). Cold water is available in all prisoners' rooms and in some there is also a shower. Some prisons have a problem with low water pressure resulting in there not being enough water for all prisoners.

Rahova prison has a problem with the heating system and the prison is cold. Prisoners can shower each day if working. However, the water pressure is poor and it does not work well on the third floors of the sections. The prison has its own well so the cost is reduced. Prisoners in the focus group said that there was:

a lack of hygiene and cleanliness on the top floor and the building was damp and mouldy. Due to the cold in the prison some prisoners have fires in their rooms and this resulted in there not being enough electricity to operate the showers properly. (Prisoner focus group, Rahova prison 2004)

At Târgșor prison when the prisoners arrive they are told about collective and individual hygiene. An NGO, run by a religious group, provides soap and toothpaste for the prisoners. Prisoners from the focus group said that even though there was a shower in their rooms they were unable to use it but shared one on the section. Due to the lack of hot water the prisoners reported that, in reality, those who were working could shower once per week and those not working could shower once every ten days.

At Târgșor prison in the modernised section there are twelve to fourteen beds per room but in the older sections there are twenty to thirty beds per room. This number of prisoners, together with the restricted use of showers, does not help to promote hygiene. However, conditions are expected to improve when these sections are modernised and the large rooms will be reduced to ten beds.

The food provided for prisoners was considered to be very good by prison staff and it is checked at every meal by staff from the health care department in the prison for calories and nutritional value. Prisoners are employed in the kitchen to prepare the food under the supervision of a professional cook.

In Slovakia there is currently a huge range in the number of prisoners allocated to each room. Category D prisoners are given a room to themselves but there are instances of 40 people sharing one room. The Prison Service's programme of refurbishment is reducing the number of prisoners per room.

Prisoners from the focus groups at Trenčín and Sučany–Martin prisons reported that, although the food was of reasonable quality, there was not enough of it. At Trenčín open and semi-open prison, the food was brought in from the hospital as the open and semi-open department did not have catering facilities.

Hygiene and cleanliness was not an issue raised by staff in the sample prisons in Slovenia; however prisoners thought:

the liquids provided for cleaning are really terrible. You can get washing up stuff, but they're useless because they're so thin, and sometimes you'd like to have stuff to really clean, but you can't get it, and you can't buy it either. There are many other things, which prisoners would like to buy, but they're not allowed. (Prisoner focus group, Dob prison 2003)

The medical officer, or another designated member of staff, reports on the quality, quantity, preparation and serving of the prison food to the director of the prison. According to Walmsley, 2003:488

the quantity and quality of food are said to be close to average standards in communal catering outside. The prison administration reports that it is able to provide a balanced diet, including meat, fruit and vegetables. Special diets are provided for those who need them for health reasons, for religious reasons or because they are vegetarians.

On the whole, prisoners from the focus group considered the food to be not bad:

but it's the same all the time. Sometimes I get the feeling that every Monday you're served the same dish, every Tuesday you're served the same dish. After awhile, you really can't bear it any more! (Prisoner focus group, Ljubljana prison 2003)

Summary of health care

Confidentiality was not seen as key issue in all the sample prisons and the degree to which it was maintained differed across the countries. The responses of staff, who felt they had to know who was HIV-positive or hepatitis positive, indicate the need for further staff training about communicable diseases.

In some countries measures had been introduced to improve prisoner confidentiality. In Estonia, for example, access to prisoners' files had been reduced. In some prisons prisoners themselves broke confidentiality about their HIV status due to pressure from the 'prisoner hierarchy'. In some prisons fellow prisoners were not supportive of those who were HIV-positive. This underlines the need for confidentiality and increased provision of information to reduce negative attitudes towards HIV and other communicable diseases.

In some of the countries 24-hour medical cover is provided in prisons. However, this is not always the case and this has led to medicines being distributed by security staff at weekends and during the evenings. Some security staff indicated that this could be problematic, as they were not trained in this area. The health care provision in prisons was considered to be equivalent to that provided in the community by all the countries visited. However, practices such as security staff being responsible for distribution of medicines, difficulty in recruiting medical staff and budget deficiencies, do raise doubts about equivalence being reached in all the prison systems visited.

The majority of the countries have initiated refurbishment programmes to improve the living conditions of prisoners. This is a gradual process constrained by lack of finances in some of the countries. The availability of hot water for showering and the number of showers available was raised in most of the sample prisons. It is evident that regulations stating that prisoners should shower once per week, or more often for working prisoners and women, are not being complied with.

Chapter 7

Prevention and harm reduction

Prevention and harm reduction programmes in prisons are the most widely used methods because they are regarded as the least controversial by prison authorities (Polonsky, *et al.*, 1994; Lines, 2002). Most harm reduction programmes concentrate³⁶ on the provision of knowledge about HIV transmission and the risks associated with illicit drug use. In prisons harm reduction measures aimed at HIV prevention and harm reduction related to drug use:

are widely understood to include the provision of educational programmes, condoms and water-based lubricant, bleach (liquid or tablets), clean needles (syringes), substitution therapy for opiate addiction (methadone maintenance treatment), and sterile implements for tattooing / piercing / scarification. Some or all of these measures also protect against sexually transmitted infections and blood-borne infections (including hepatitis A, B, C). Harm reduction in relation to drug use means reducing the harmful consequences of drug use without necessarily reducing drug consumption. The major harmful consequences of drug use include blood-borne viruses such as HIV/AIDS, hepatitis B and C, overdose, various other medical and psychological conditions, and involvement in criminal and other antisocial activities. Harm reduction measures include education, clean needles (syringes), and substitution therapy for opiate addiction (methadone maintenance treatment). (Canadian HIV/AIDS Legal Network, 2004:22)

The political context in which prisons have to operate has led to variable provision of harm-reduction measures in the sample countries. The key area in which measures are required to meet the needs of increasing numbers of problematic drug users in prison is the provision of harm-reduction information about drugs and communicable diseases for staff and prisoners, provision of condoms, bleach, substitution treatment and needle exchange.

Harm-reduction information about drugs and communicable diseases

Provision of harm-reduction information for prisoners and for staff was inconsistent across prisons, within countries and between countries. Sometimes the only harm reduction information was that given at reception to the prison and this

36 For further information see: *Understanding Harm Reduction*, Centre for Harm Reduction, available at http://www.chr.asn.au/freestyler/gui/files/Understanding_Harm_Reduction.pdf

information was usually minimal. Other prisons provided much more information, usually in partnership with NGOs.

Staff at the Bulgarian Department for Punishment Execution said that all prisoners are given information about drug taking and communicable diseases and how to get treatment while in prison. This did not seem to be the reality in the two sample prisons. There was no clear prevention and harm-reduction policy in either of the sample prisons. Some information was given to prisoners at reception to the prison but the content of this information was variable.

Prisoners from the focus group at Troyan prison said that, at entry to the prison, they were told nothing about harm reduction. Despite this, the prisoners thought that they were quite well informed and knew all that they needed to know about harm reduction. At Varna prison some information about prevention and harm reduction is provided to groups of prisoners during the assessment period at entry to the prison. According to the prison psychologist, the injecting drug users get more individual information as it takes a long time for drug-dependent prisoners to talk about their problems and there is a need for individual work first before group work. The information that is given is to recommend some videos (every Thursday the prisoners watch videos and educational films) and the psychologist borrows some videos from a clinical psychologist working in the community. For those prisoners who are literate, there is also a lot of literature in the library on hepatitis. The prisoners in the focus group said that they 'inform each other and tell the younger ones how to survive as the leaflets about risk behaviour in the prison are outdated and we don't use the library' (Prisoner focus group, Varna prison, June 2003). At Lovech prison, according to the prison doctor, the prison administration considered that information about safer sex should be provided for prisoners 'as it is no secret that there is a lot of homosexual contact [amongst prisoners]'. However, as the doctor said: 'prisoners don't want to hear from a medical person about safe sex and the related risks'. However, the previous year, during the drug programme the doctor felt that he had managed to break the ice between the prisoners and himself and was then able sometimes to discuss such issues as condoms and safer sex. Although it is not officially part of the social worker's role to provide prevention and harm reduction information, one of the prison social workers said that there was no actual obstacle to doing this and they have provided information in the form of leaflets on several occasions like World AIDS Day.

The provision of training for staff in the sample Bulgarian prisons was variable. The security staff at Varna prison have had a lecture on drugs but this was not really specialist training. The head of security staff said that the security staff know something about drugs and can recognise when a prisoner is high. Regarding risk prevention, they do not use gloves but they know what to do in risk situations. At Lovech prison in the previous year there was training for the guards about drugs. Social workers and senior staff have also had this training. Some staff who were interviewed said that they had not received training about communicable diseases or drug awareness. This area of training was considered to be important, especially as the number of drug-dependent prisoners coming into the prison is increasing.

At Varna prison the previous doctor, who was a drug specialist, had provided some training on drugs for staff. Most staff felt that there was a need for training

in the areas of drugs since, drugs being a new problem for prisons in Bulgaria, almost nobody in the prison had a lot of experience of the subject.

In Estonia information booklets are provided for prisoners, both in Estonian and Russian, containing information about communicable diseases, reasons to have the HIV test and information about cleaning injection equipment. As with all central strategies, the way they are implemented in each prison is dependent on the individual prison management. The AIDS Prevention Centre has also provided training for staff in drugs and communicable disease prevention. A key time identified by the prison administration for the provision of harm-reduction information is during the two week assessment period at reception to prison. This assessment period happens at Viljandi prison but not at Tartu prison. Prisoners at Viljandi prison are also given harm reduction information in the school and from the social workers. During the summer there are some courses provided at Viljandi prison by the Ministry of Justice on sexual health for staff and prisoners. At Tartu prison harm reduction information is given to the prisoners and leaflets are available on the sections. There are materials in Estonian and in Russian about AIDS, TB and hepatitis C and the risks of transmission. Prisoners in the focus group felt that although there were:

leaflets available on the section, not many of us are well informed about this issue [communicable diseases]. Most prisoners would not be particularly interested in information about risk behaviour. Leaflets are OK but I would prefer talks. (Prisoner focus group, Tartu prison, May 2003)

One head of department at Tartu prison said that the provision of harm-reduction information was co-ordinated by the medical department. However, other prison staff who were providing some information to prisoners were not aware of this and so the work did not appear to be co-ordinated. Staff involved in providing harm-reduction information were the psychologists, social workers, chaplains and medical staff. It was not clear whether every prisoner is given harm reduction information or whether this is targeted at known drug users or those prisoners who specifically ask for the information. A general programme is being planned by the prison administration for all sentenced prisoners about the risks of HIV and it will be delivered by the prison doctors. In the future, the medical department will provide training for prisoners about prevention, which will be delivered by the nurses.

The Estonian AIDS Prevention Centre has also provided training for prison staff in drugs and communicable disease prevention. After this training further money has been obtained from the US Embassy, which is being used to train prisoners and staff who will disseminate the knowledge to a wider group of staff within the prisons. It is after staff have received some training, that HIV-positive prisoners are integrated into the main prison population as, by this time, the attitudes of prison staff and prisoners are less negative. In Tartu prison training for guards in recognising the symptoms and signs of drug use have been prioritised and most of the guards have now been trained in this subject. There is a prison trainer who provides a range of courses. All the guards and most of the specialist staff have had training on drugs provided by a drug specialist.

According to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Latvia needs a policy that changes the practice of ostracising HIV-positive prisoners and that includes a programme of education and information for both prison staff and prisoners about such issues as methods of transmission of HIV and means of protection (CPT, 2001). Previously, in some prisons, health staff ran lectures about harm reduction, HIV and communicable diseases. The AIDS Centre offered information and training to both staff and prisoners in some prisons. A specialist from the centre provided information about HIV prevention through posters, leaflets and video films. In theory, information about risk behaviour is given to all prisoners at reception through leaflets. However, prisoners thought that they did not receive comprehensive information about risk behaviour and HIV. Prison staff also acknowledged that information is not given on a regular basis but when medical staff consider that it is needed. Prisoners acknowledged that some information is provided if they ask for it:

we got no information about risk behaviour, just rules about how to behave in the prison. There have been some lectures but not all of us could go to them. The psychologist, if you ask her, will tell you about things. There are some leaflets on the unit. We would like more information. (Prisoners, Ilguciema prison 2003)

One member of staff said that he holds a meeting once or twice a month and discusses issues about drugs and harm reduction. Twenty of the prisoners on his unit work and so they cannot attend meetings during the day; he holds them at weekends so that they can all attend.

Some staff interviewed at Pārlielupes prison in Latvia said that they have had information about communicable diseases from medical staff and the AIDS Centre. There were also posters in the prison. These staff also felt that probably they had not had enough of this training. Staff training and the employment of drug specialists are also viewed by some staff as crucial to support drug users in prison. The medical staff provide training in the sample prisons on HIV and other communicable diseases. Additionally, the AIDS Prevention Centre sometimes provides training.

In Poland prisoners have occasional access to informational leaflets that are also handed out to them at admission to prison. The information on how to reduce harm related to drug use is given to drug-using prisoners by medical staff, psychologists and case managers who have been trained as HIV-educators by NGOs (especially MONAR). Staff employed at the therapeutic units for drug-dependent prisoners are regularly trained about HIV, harm reduction and drug dependency issues. The majority of staff from the therapeutic units are also designated as qualified trainers on HIV prevention by the National AIDS Centre. Over 100 psychologists and case managers have received this training and about 30 of them have received additional training in drug-demand reduction, as an addition to the HIV training.

The extent of the harm reduction information that Slovakian prisoners received varied between the sample prisons. Upon arrival at Bratislava prison, the prisoners' medical history is taken, they have a TB X-ray and they are given some

information about harm reduction. This warns them against homosexuality, piercing and self-harm and they sign a form to agree that they have received this information. Information given at this time does not make an impact on prisoners, however. Prisoners from the focus group said that:

we had no information about harm reduction regarding sex, tattooing, piercing or injecting drug use from the pre-trial prison. After the initial examination there is not a lot of time to read the information on the paper but we sign it anyway. There is much more information given here at the drug free unit. (Prisoner focus group, Trenčín prison 2004)

Prisoners from both focus groups considered themselves to be well informed about risk behaviour and methods of prevention:

risk behaviour and prevention was explained to us by a specialist – if a girl wants me to I will use a condom. I know a lot about HIV: we talk about it with the staff a lot. Condoms are available from the prison shop but we wouldn't buy them. (Prisoner focus group, Sučany-Martin prison 2004)

every week we have lectures on drugs and alcohol about how they affect the human body. Everybody knows what to do now to protect themselves. We are well informed by the educators. The information provided is sufficient. It is up to us to follow or forget the rules. Those who like men (not among us) should have a regular supply of condoms. In fact, condoms should be available to everyone. (Prisoner focus group, Trenčín prison 2004)

Security staff in Slovakian prisons receive some information about HIV and communicable diseases during their basic training.

Harm reduction information was not provided to all prisoners in the sample prisons in the Czech Republic and a number of staff interviewed felt that it was not required. However, prisoners in the focus groups felt that they did need more information:

we had some leaflets about HIV but no course about it. The juveniles get more information. We need this kind of information. I don't think we understand about HIV and other things because we [prisoners in the group] have different knowledge with different abilities to understand things. The social workers are just telling us about the theme of the day, but they don't quite realize that there are people who don't have the abilities to understand and grasp what they actually tell them. Some people understand and the social workers don't really care and in the end they ask if everybody understands and everybody just nods. (Opava prison, Prisoner focus group Male prisoners 2003)

Staff at Opava drug treatment unit said that prisoners receive information about hepatitis on a regular basis. At the other Czech sample prison, Příbram prisoners had differing views about the information and treatment about hepatitis C that they had received:

I was only told that I had hepatitis C and I was put on a diet, but otherwise I wasn't told at all what I should do to minimise the symptoms of the disease.

Other prisoners with hepatitis C were getting medication but I was not given any medication. I don't know why I didn't get any information. (Prisoner focus group (male), Příbram prison 2003)

I knew about the risks of hepatitis C, but the thing is if you live with other drug users, you're going to end up having it one day or another, because either you get it through needles, or if not you can get it through sexual intercourse. You might sleep with another drug addict who doesn't tell you that she's infected with hepatitis C and you end up getting it. (Prisoner focus group (male), Příbram prison, 2003)

The above views of prisoners indicate a need for them to receive clear information about their health and continuing harm-reduction information.

Prison staff in the Czech Republic have training on how to detect and recognise prisoners with symptoms of communicable diseases. The General Directorate of the Prison Service also invites external experts to talk to staff about various issues, such as HIV and the influence of drugs (General Directorate of the Prison Service, Head of Social Work 2003). In addition, staff working within specialised units in the prisons receive specialist training. This training focuses on skills to deal with prisoners and addresses assertiveness, knowledge of drugs (terminology, definition), and communication (General Directorate of the Prison Service, 2003). At Příbram Prison there is a team of lecturers providing information on specific issues, as requested by the staff. The prison director considers the level of educational training available for staff in the prison to be excellent:

especially compared to that prior to 1989. Before 1989 the education offered to prison staff was only the induction course, whereas today it is a life-long process. (Prison Director Příbram prison, 2003)

Training and information on drugs, drug use and communicable diseases are offered during the induction period to members of the security staff.

Staff at the Hungarian Prison Department said that currently the introduction of harm reduction mechanisms was not a priority as the threshold for the need to do so had not as yet been reached in Hungarian prisons. It was not clear whether harm reduction information was given to all prisoners in a consistent way. One member of the prison staff said that:

if I am asked by prisoners for such information [harm reduction] I will provide it. There has not been a need so far to make a general presentation about harm reduction because the Prison Department provides a video and it is given to the prisoners to watch. (Prison Staff, Budapest Central prison, 2003)

The prisoners in the focus group at Baracska National prison said that they had been shown films and received other information. This was considered to be important because 'knowing about communicable diseases is in everyone's interest, not just for those here on the drug free unit'. Staff training about communicable diseases and drugs was not provided at Baracska National prison and the staff tended to get information for themselves. Some staff did not think there was a need for more information as this was the responsibility of the health care department.

In Lithuania prevention and harm reduction were key issues, especially in one of the sample prisons, Alytus Correction House where there had been an outbreak of HIV infection amongst prisoners. The HIV outbreak at Alytus Correction House acted as a catalyst for discussion at governmental level about preventing drugs getting into prison and the implementation of harm reduction measures. Prisoners from the focus group said they were informed about HIV, sexual contact and the risk from tattooing both in the pre-trial prison and in the sentenced prison. One prisoner from the focus group, who was a drug user prior to coming to prison, said that he did not share needles in the community and that in the prison there were regular conversations with staff about using drugs and risk behaviour. Prisoners receive lectures about communicable diseases in their sections. Overall, the prisoners are considered to be well informed “as they are now better informed about how to get diseases but this does not necessarily stop risk behaviour” (Prison staff, Alytus Correction House 2004). The platoon commanders³⁷ [officers in charge of a section in the prison] have a social work role with prisoners:

in my section there are a lot of problematic drug users and I talk to them about drug use and whether they would like to stop taking drugs. I also provide information about prevention (written information, leaflets, etc.) and I discuss this with them. I organise lectures for the section by people from the AIDS Centre and other people. I leave information in the living area of the section. It would be good to have some video information to show the prisoners. (Platoon Commander, Alytus Correction House 2003)

According to the Lithuanian Correctional Affairs Department, the medical staff in the prisons provide staff training about communicable diseases, especially after the HIV outbreak at Alytus Correction House. Healthcare institutions provide some lectures and health care departments in the prisons provide some written materials. The provision of information is now done in a more interactive way. Information should be given to prisoners at reception to the prison via leaflets and posters. Each prison decides the content of the information (Semenaitė, Correctional Affairs Department 2003). At Kaunas Juvenile Pre-trial prison and Correction House, drugs and communicable diseases training for staff is organised by the Correctional Affairs Department and also by staff in the prison. The medical staff at Alytus Correction House provide communicable diseases training via lectures for staff as part of a general programme of staff training. At Alytus Correction House there are a lot of new, young staff and the Correctional Affairs Department provides constant training; however, there is also a lack of time and finances to release all staff for training.

The General Directorate of Penitentiaries in Romania has implemented an HIV programme using peer educators. This programme was piloted in one prison in each of four regions. There are a total of fourteen prisons in these four regions and the learning from the four pilot prisons was disseminated to these fourteen prisons. The programme will soon be expanded to add another thirteen prisons from other regions. In addition, funding from the SOROS Foundation

37 Platoon commanders have a similar role to educators, case managers and pedagogues in other prison systems.

will enable an expansion of the programme to cover all the prisons, including two centres in the Moldavian region of Romania. The staff involved in the project were medical staff and educators who, after training, identify and train the prisoner peer educators. Information sessions were organised for the staff in each prison with trainers from ARAS (Romanian Association against AIDS). In the four prisons monthly activities for the prisoners and training sessions for prison employees about HIV and harm reduction were developed. During these sessions the prisoners were selected to be the peer educators. In total, forty peer educators were selected from 350 prisoners. To highlight the project a poster contest on HIV prevention was organised. The best three posters were chosen and the winning poster was copied and distributed to the prisons. Sixty prison employees were trained in HIV and communicable diseases prevention and a further twenty employees were trained as HIV counsellors. The project was evaluated using a range of methods at the beginning and end of the project³⁸.

In one of the sample prisons in Romania the prison director thought that there was currently a good HIV prevention programme in place. Additionally, prisoners have television in their rooms and there are currently a number of very explicit advertisements about the dangers of HIV. The prison director said that it was difficult to select the right staff to take part in the programme with ARAS. Some of the prisoners in the focus group had taken part in the ARAS programme and they considered themselves to be well informed about harm reduction from the course, the leaflets provided by the General Directorate of Penitentiaries and the television. Târgșor women's prison is one of the regional centres that worked with the ARAS programme. The staff trained by the project are now working with groups of prisoners on HIV and drug use and providing information and other related activities. Prisoners in the focus group felt informed about HIV:

we were given leaflets last night, had counselling, watched TV, and had group discussions. We think we are well informed about HIV and it would not be a problem to live with someone who was HIV-positive. We don't need condoms in this prison; it would possibly be a good idea in male prisons but that's their problem! Romanian men are not keen to use condoms. (Prisoner focus group, Târgșor prison, 2004)

38 The project was evaluated at the end to verify its impact and the methods used. A questionnaire was given to a representative group of prisoners involved in the project. Also a focus group was organized to evaluate the knowledge and attitude of the prisoners and prison employees towards:

- Sexually transmitted infections (transmission, protection, symptoms etc.);
- The right use of condoms;
- HIV infection (transmission, protection, attitude towards PLWA, etc.);
- The distribution of condoms when leaving the penitentiary.

The results of this evaluation showed that:

- 30% of the inmates made incorrect statements about HIV transmission;
- 40% consider that "if you do not have sexual intercourse, you can not get HIV"
- The majority considered condoms to be the best method of prevention.
- The majority considered health education in prison as very important.

During the last month of the project an evaluation of the activities was made. The main objectives of this evaluation were: to identify the major outputs of the project; to identify the factors which affected the achievement of the planned objectives and to establish the possibilities to continue and sustain the HIV/AIDS prevention activities in the four prisons after the end of the project.

The deputy director of Târgșor prison thought there had not been enough training for staff about drugs. He thought that staff were better informed about communicable diseases both because of the training they had had and the information provided in the media.

In Slovenia programmes for raising awareness of communicable diseases, risk behaviour and prevention are underway. These programmes are intended for prisoners and prison staff. The programmes are implemented in the form of lectures by a specialist doctor and by distributing leaflets about prevention³⁹. Not all prisoners receive these leaflets but prisoners at Ljubljana and Ig prisons receive information from the Association for Harm Reduction Stigma NGO (Head of Treatment, National Prison Administration 2003). Health care staff at Ljubljana prison thought that harm reduction was done better in the community and that there was not enough being done in the prison where:

officially there is no intravenous drug use happening in prison, but in reality there is. The national prison administration does not admit or recognise that this happens. I am in favour of needle exchange in prison, but the national prison administration is not in favour of it. (Health Care Staff, Ljubljana prison 2003)

The NGO Foundation Robert used to work in the area of harm reduction in Ljubljana prison but, for a variety of reasons, no longer come to the prison. Health care staff at Dob prison felt that more time was needed to provide information about prevention. Prevention information is provided by two therapists and not by the medical team. The medical team distributes information leaflets and tries to inform every new prisoner about health issues but this was not considered easy to do due to a lack of resources and time.

The Slovenian National Prison Administration provides a health-education programme for staff and prisoners. The aims of this programme are:

- to teach people preventive behaviour;
- to overcome fear of these diseases;
- to counter the stigmatization of the infected.

To meet these aims pamphlets have been produced and distributed among the prisoners and medical advice is given to encourage prisoners to maintain good personal hygiene, to disinfect their living quarters and so on. Staff are informed that they should use latex gloves whenever there is a possibility of contact with blood. Prison staff are required to receive training about all the dangers associated with all the viruses and to provide this information to prisoners. However, Hren *et al.* (2002) argue that 'in reality prisoners do not use the assistance given to them by the prison staff'.

Programmes for raising awareness and prevention of infectious diseases intended for prisoners and staff in prisons are provided via lectures by doctor-specialists and via the distribution of leaflets (Head of Treatment, National Prison Administration 2003). Staff at Ljubljana prison had diverse views about the provision of training they received:

39 The National Prison Administration receives leaflets about HIV and AIDS from the Institute of Public Health.

training for staff was provided at first, especially in '96-'99 when drug problems increased. Since 2000 we have had much less. In 2002 there was one seminar on methadone. There is no induction training provided for the staff compared to prisoners who get an individual induction from the pedagogue within the first 4 days of imprisonment! (Specialist Staff, Ljubljana prison 2003)

Nursing staff in the prison considered they were well trained about methadone and had received training from the Addiction Centre:

the medical team from the Addiction Centre acts as supervisors. As Slovenia is a small country it is easy to meet colleagues regularly. (Nurse, Ljubljana prison 2003)

Other staff felt that too little training is provided about working in prison and that more education is needed for the security staff on drug dependency, sexual abuse and alcohol, as they have some knowledge about it but not enough (Staff, Ljubljana prison 2003).

Condoms

The discussion about whether condoms should be provided in prisons is not straightforward. It is important to remember that condoms alone will not solve the problems of the transmission of HIV. It has been argued by Reyes (1997) that different cultural settings may call for different solutions and that

condoms will unfortunately not solve the problem of sexual transmission of HIV even in Western settings, let alone in the contexts mentioned [Eastern Europe (ex-USSR) and Africa]. The important point to be made is that politicians, administrators and even medical staff unfamiliar with prison realities must not be lulled into complacency about HIV transmission just because of the advent of the prison condom dispenser.

Although, in theory, condoms are available in prisons, in most of the sample prisons, in reality they were not accessible to prisoners.

Condoms are not available in Bulgarian prisons, nor can they be bought at prison shops. The prevailing view amongst staff at the Department for Punishment Execution was that condoms should not be made available as homosexuality is a crime and by providing condoms the Department for Punishment Execution would be helping prisoners to break the law. However, staff in the Bulgarian sample prisons were generally in favour of providing condoms to prisoners. Previously in Lovech prison there were programmes (from the community) in which condoms were supplied to the prison and the social workers distributed them to the prisoners. However, when the project finished there was no money to continue to supply the prisoners with condoms. The prisoners in the focus group were also in favour of condoms being available in the prison: "They should be available for those who want them and we would take them and use them".

In the Czech Republic, condoms were available in the prison shop at both sample prisons. In the Czech Republic the overall feeling amongst staff in the sample prisons was that condoms and needle exchange were not needed in prison. Although condoms were available in the prison shop, prisoners, with limited income and given the taboo nature of men having sex with men, would be very unlikely to buy them. .

One response in Estonia to the HIV epidemic in prisons is to supply condoms for prisoners. The prison psychologist at Viljandi prison also provides harm-reduction information as well as condoms to the prisoners who want them. She dispenses the condoms because the medical staff do not consider this to be part of their role. If prisoners go on home leave they are asked if they want condoms and they usually take them.

In Latvia condoms were provided two years ago by the AIDS Centre project but now they are no longer available to prisoners. During the project the unit chiefs distributed the condoms to the prisoners and condoms were also provided in the 'visit hotel'. Prisoners can now order condoms from the prison shop if they want them.

Although the Lithuanian Correctional Affairs Department provides condoms for use during the long visits, they are not provided for general use in the prison. Prisoners can buy condoms from the prison shop. Condoms are provided (about 4 or 5) for each long-term visit. Some condoms are circulating around the prison from those not used during the long visits (Prison staff, Alytus Correction House, 2003). All the prisoners in the focus group at Alytus Correction House were in favour of condoms being provided for all prisoners and not just for the long visits.

In Poland the importance of condom distribution is widely accepted by the prison administration. Normally condoms are available in prison shops and canteens (but there is no obligation to sell condoms in canteens). Condoms are also distributed free of charge. However, there is no systematic distribution of condoms in all Polish prisons due to a lack of financial resources necessary to purchase them. Condoms are also distributed to prisoners during the campaigns held by UNDP, National AIDS Centre and other organisations.

Harm reduction is a key issue for the Romanian General Directorate of Penitentiaries. A range of visits to other countries and discussions with staff have been undertaken to find out what models of harm reduction best fit the Romanian situation (Head of Health Care, General Directorate of Penitentiaries 2004). Currently, condoms are given to prisoners (in the regions where programmes are in place) when they are released from prison and when they go on home leave. To introduce condoms into prisons for general use, the prison administration feel there is a need for training to change the attitudes of both staff and prisoners. As the head of health care at the General Directorate of Penitentiaries remarked 'it takes a while to break down barriers. Introducing condoms into prisons is a big problem and getting prisoners to accept them – we can't just put them in prison: first we need consensus from prisoners'. The Director of Rahova prison reinforced the opinion that condom provision was a very touchy topic due to prevailing social mores. The NGO ARAS⁴⁰ did provide condoms during their programme with the prison.

Condoms are not provided for prisoners in Slovakia.

In Slovenia condoms are made available for prisoners' general use. Condoms used to be left discreetly in the toilets where prisoners could help themselves but the condoms got damaged and prisoners at Dob prison now can have access to condoms from the security staff. At Ljubljana prison nurses distribute the condoms as they are no longer put in the toilets because prisoners played with them. Prisoners also tend to get condoms from their families during the visits. According to the study by Hren (2002), although condoms are officially available, the majority of prisoners were not aware that they could obtain them from the prison. Less than a quarter (23.2 per cent) of the respondents said they could always get condoms and 16 per cent said they were never able to get them.

Even when condoms are available, it is usually very difficult for prisoners to access them in a confidential manner. Confidential access is a key issue where the taboos regarding sex between men are so strong. As mentioned in respect of Romania, staff training and prisoner training are key to the successful implementation of condom provision.

Bleach

One means of reducing the transmission of HIV through the sharing of needles is by giving prisoners access to bleach⁴¹ and information about how to use it for cleaning needles and syringes. In some prison systems the bleach is provided in tablet form rather than in liquid form. The provision of bleach is not always seen as acceptable to prison authorities:

on the grounds that it may be perceived as condoning an illegal act that has contributed to many prisoners being incarcerated in the first place. It has also been argued that making bleach and information on how to clean injection equipment available may encourage non-users to experiment with injection drug use, and that bleach could be used as a weapon against staff. However, the experience in those prison systems that have made bleach available to prisoners has shown that distribution of bleach has not compromised security within penal institutions. (Canadian HIV/AIDS Legal Network, 2004: 11)

Although it has been well established that bleach helps to eliminate HIV, it is not considered to be fully effective in reducing hepatitis C infection (Hagan, 2003). Research (McCoy et al., 1994; Dolan et al., 1998) also indicates that IDUs may not always remember how to use bleach to disinfect injecting equipment and may not always avail themselves of bleach even when it is available:

the probability of effective decontamination is further decreased in prison as cleaning is a time-consuming procedure, and some prisoners may be reticent to engage in any activity that increases the risk that prison staff will be

40 A further discussion of the ARAS programme can be found in the HIV section of this report.

41 Disinfection programmes have been used in settings where needle exchange is not feasible. It is hoped that drug users who disinfect their injection paraphernalia after use with chemical substances (usually household bleach) adequately decontaminate the equipment before reuse. The effectiveness of disinfection procedures depends to a large extent on the method used, is of varying efficiency, and is therefore only seen as a second line strategy in needle-syringe programming. (WHO, *Harm Reduction Approaches to Injecting Drug Use*, WHO, 2004 <http://www.who.int/hiv/topics/harm/reduction/en/>)

alerted to their illicit drug use. While offering bleach to prisoners is a positive step, problems with the uptake of these programs, as well as the limited effectiveness of bleach in preventing hepatitis C infection, suggest that this intervention alone is clearly an inadequate response to drug-related harm in prisons. (Canadian HIV/AIDS Legal Network, 2004 :12)

Bleach is not provided to prisoners in Bulgaria, Hungary, Romania and Slovakia.

In Poland, according to the prison administration, there is no need to provide bleach due to the shift in the community away from injecting in drug use consumption patterns that is also reflected in the prison setting. In addition only the wealthy prisoners would be able to purchase a syringe in prison, which again reduces the need for bleach. Bleach is however available in that it is used to disinfect the cells, so in one way or another prisoners can obtain it.

In Latvia a project from the AIDS Centre supplied bleach (that prisoners had access to) and some posters about how to use it for cleaning injecting equipment. However, the provision of bleach stopped when the project finished. In Estonia and Lithuania bleach is provided and prisoners are informed that it can be used for cleaning needles and syringes. The bleach in Estonia is distributed via the medical department.

In theory, in Slovenia bleach is allowed in prisons and should be available to prisoners, but financial limitations are making condoms and bleach difficult to provide (Hren, 2002). This was confirmed by the head of security at Dob prison:

there is no distribution of bleach in the prison and tattooing is forbidden. The general use of disinfectants for cleaning the prison is a problem but they need to be controlled as they are drunk by alcoholics. (Head of Security, Dob prison 2003)

Needle exchange

The risk of infection is much higher for injecting drug users if they reuse or share injecting equipment. Prisoners may well be aware of the risk of using and sharing needles in prison, but some will still use a needle that may not be sterile because there is not an alternative available. As discussed earlier, drug injecting is occurring in some prisons within the sample countries and also sharing of needles.

There is currently no discussion about the introduction of needle exchange programmes⁴² into prisons in Hungary, Romania or Slovakia. When asked about the possibility of having a needle exchange in Lovech prison in Bulgaria the prison director responded that at the moment they are concentrating on stopping drugs coming into the prison. He felt that introducing needle exchanges might be dangerous for the future as, at the moment, the whole prison system was using the approach of supply reduction rather than focusing on prevention. They do not

42 *Needle-Syringe Programming (NSP)* aims to ensure that those drug users who continue injecting have access to clean injection paraphernalia, including needles and syringes, filters, cookers, drug containers and mixing water. Specific interventions that equip drug users with sterile injection equipment usually also collect used needles and syringes, and are commonly known as 'needle exchange programmes' (NEPs). Their ability to break the chain of transmission of HIV and other bloodborne viruses is well established. (WHO, *Harm Reduction Approaches to Injecting Drug Use*, WHO, 2004 <http://www.who.int/hiv/topics/harm/reduction/en/>)

want to encourage the growth of drug use but prefer to use therapy and peer support with the prisoners in the first instance to stop them using drugs. The prison director at Varna prison was open to the idea of trying a needle exchange in prison, but at the moment there is no money to do this. As more prisoners have the opportunity to work outside the prison, he envisages more drugs coming into the prison and, as a result of this, more prisoners will use drugs and the need for such initiatives as needle exchange will become more acute.

The director of Tartu prison in Estonia said that there has been some discussion about needle exchanges being made available inside prisons but he would prefer this not to happen at the moment as he thought the focus should be on reducing the supply of drugs into prison. However, as HIV increases he thought that they might have to consider introducing needle exchanges.

Although drugs in prison and risk behaviour are widely acknowledged in Latvian prisons, there are no needle exchange programmes in place or under consideration. According to the head of security in one sample prison, current policy is 'better to try prevention first'. However, to put this in context, there is only one needle exchange programme for those who are HIV-positive in the community as a whole. The AIDS Centre runs this programme in Latvia's capital, Riga.

The general view of staff working in the two sample prisons in Poland and staff from NGOs is that there is no need for needle exchanges in the prisons due to the low incidence of injecting drug use in prison.

While there are no needle exchanges in Lithuanian prisons, the Correctional Affairs Department has money for a needle exchange pilot project but there has not been a decision about where or how to implement it.

Currently the Slovenian national prison administration is considering a pilot needle exchange project. The recommendations are that needle exchanges should at least be available in Dob and Ljubljana prisons and Radeče, the young offenders prison. The health care staff at Dob prison were in favour of a needle exchange being available. In order for it to be successful, confidentiality would need to be guaranteed and one used needle exchanged for one new needle. The health care staff made the point that in reality this would not be feasible due to the shortage of staff.

Substitution treatment

The provision of substitution treatment⁴³ as part of harm reduction for problematic drug users can also provide an opportunity to inform and engage drug users in other drug treatments (WHO, 2004).

In Poland and Slovenia, substitution treatment is available in prison. However, substitution treatment is not available in *all* Polish prisons, nor is substitu-

43 *Drug substitution treatment* involves the medically supervised treatment of individuals with opioid dependency based on the prescription of opioid agonists such as methadone. Whilst the primary goal of drug substitution treatment is abstinence from illicit drug use, many patients are unable to achieve complete abstinence, despite improvements in their health and well being. However, there is clear evidence that methadone maintenance significantly reduces unsafe injection practices of those who are in treatment, and hence the risk of HIV infection (WHO, *Harm Reduction Approaches to Injecting Drug Use*, WHO, 2004 <http://www.who.int/hiv/topics/harm/reduction/en/>)

tion treatment available in the community in *all* areas of Poland. This has caused problems for the introduction of this treatment in prison, as it cannot be guaranteed, when prisoners are released, that they will be able to continue their treatment in the community. The key argument of those experts and practitioners from the outside is that providing substitution treatment in prison is only justified if it is possible to continue it in the community. Despite these arguments, substitution treatment programmes have been established in some Polish prisons. The main problem with the implementation of the methadone programme in prison is the lack of a national strategy on the implementation of substitution programmes. For example, when participants in the substitution treatment programme in the pre-trial prison are sent to other prisons in Poland, the continuation of the treatment is unlikely or impossible. At the time of the visit the only substitution treatment programme in prison in Poland was at Montelupich prison in Kraków. However, since April 2004, substitution treatment is available in three of the Warsaw remand prisons: Białoleka, Mokotów and Służewiec.

Montelupich prison provides substitution treatment for 10–15 prisoners but at the time of the visit there were only six prisoners on the programme. Acceptance onto the methadone programme is based on three conditions:

1. that the prisoner should be at least 21 years old;
2. that the prisoner should have had a three-year history of injecting drug use;
3. that the prisoner should have undergone three unsuccessful treatment attempts and given an assurance that he will take the methadone.

The methadone programme is not available for prisoners without medical insurance.

Substitution treatment is available in all Slovenian prisons and is financed by the national prison administration. In prisons methadone is used for detoxification (on the principle of gradual reduction) and for substitution therapy (maintenance programme). Methadone therapy is carried out in prisons on the principle of gradual reduction to the level of abstinence. The therapy is prescribed by doctors who are specialists from the network of Centres for the Prevention and Treatment of Drug Addiction (CPTDA).

Methadone treatment is divided into four categories:

- short-term detoxification: decreasing doses over one month or less;
- long-term detoxification: decreasing doses over more than one month;
- short-term maintenance: stable prescribing over six months or less;
- long-term maintenance: stable prescribing over more than six months.

The minimum requirements for placing problematic drug users on the methadone maintenance programme (MMP) are that they have an opiate addiction, have made previous detoxification attempts, are over the age of 16 and are living in the region where a drug prevention and rehabilitation centre is located, have given their written consent to be on the programme and have health insurance. The decision about starting the MMP is made by the expert team, consisting of the doctor, psychiatrist, nurse, social worker, psychologist and a therapist from the prison.

Prisoners in Slovenia who were prescribed methadone before coming to prison can remain on MMP during their sentence. Therapy can be prescribed for the first time in prisons and after release the prisoner can continue therapy in the community. In the case of transfer from one prison to another (or from police de-

tention to the prison), the therapy continues according to the recommendation of the doctor. All methadone patients in prisons have to agree to drug testing (a urine test). As part of the methadone programme, prisoners agree to participate in a psychosocial programme.

However, in reality it is only in exceptional cases that the doctors decide to allow maintenance therapy in the prisons. There are concerns about paying for the methadone in prisons and the government would prefer there to be no long-term methadone substitution treatment (Specialist Prison Staff, 2003).

In the other eight sample countries, substitution treatment was not available in prison but detoxification was available in most of the countries. In Bulgaria, for detoxification, prisoners would normally go to Sofia prison hospital. There is some methadone used in the hospital if the prisoner was using it in the community. However, there is no methadone maintenance programme available. The psychologist at Varna prison made the point that, in 2000, the Health Service declared that there were no problematic drug users and their withdrawal needs were not recognised but were seen as being due to other health problems; this resulted in the problematic drug users receiving drugs only for pain relief. Although the majority of prisoners go through withdrawal at the pre-trial prisons there are still some who come direct to the prison. There are few medicines available in the prisons for treating IDUs at the time of withdrawal and this can be a difficult time for staff. The Head of Security at Varna prison was adamant that:

drug users should not come to prison while withdrawing; they need to be somewhere else. Most cases come from the arrest houses but we have had some cases who are withdrawing. These people are very volatile and are difficult for us to manage and for the other prisoners as well. (Head of Security, Varna prison, June 2003)

The social worker responsible for the assessment unit at Varna prison said that there is not a major problem with drug-dependent prisoners as they arrive after withdrawal. However, at the assessment unit they have drug-dependent prisoners arriving every day. While most have dealt with withdrawal before, they had one prisoner who was withdrawing and even though the law said he should go to the transitional prison as a first offender, he was kept on the hospital wing so the psychiatrist could deal with him. Prisoners from the focus groups in both sample prisons had experienced very little help during withdrawal, in pre-sentence prisons or during police detention.

There is no detoxification available in Estonian prisons. The worst time for problematic drug users is in the police arrest houses where they can be kept for two weeks before they come to prison. In the central prison hospital in Tallinn there is some methadone used for detoxification. There are at the moment about 5–10 prisoners who get methadone for one month (Prison Department, Health Care Adviser: May 2003)⁴⁴. Detoxification is not in the national strategy as methadone is relatively new in Estonia, but it may be included in the future. In Viljandi prison there is no detoxification available but these prisoners will have

44 **In-patient rehabilitation of drug addicts (HIV+)**

There are three rooms opened in the psychiatric division of the prison service central hospital; in every room there are four beds. Methadone and a dosing device for exact dosing are kept in a safety box in the doctor's office.

already been in the pre-trial prisons for 1 to 18 months. There is no detoxification in Tartu prison, but pre-trial prisoners are given information and painkillers for their symptoms. It is alleged that the police do nothing for arrestees regarding detoxification, so prisoners will arrive at the prison needing treatment.

In Latvia abstinence is the main approach; serious cases of withdrawal symptoms are treated at the central hospital and other cases with anti-depressants and vitamins. However, prisoners complained about the lack of treatment or support for withdrawal. As one of them remarked:

at withdrawal there is no help and I got nothing. I was in this prison during Soviet times and I started using drugs in the prison and you wouldn't believe what happens in here. There is no help at the time of arrest and they only give you useless medication. (Prisoner, Pärlielupes prison 2003)

Substitution treatment is currently being discussed by the General Directorate of the Czech Republic Prison Service. The NGO Sdružení Podané Ruce⁴⁵ is not currently included in this debate. Staff at the NGO felt there was a need for more information exchange and collaboration between themselves and the prison service. The opinion of a member of staff at one NGO was that:

substitution treatment is a long-term issue and it won't happen soon in the Czech Republic because prison staff, including the specialised staff, are against it. Substitution treatment is seen as some kind of favour to the prisoners. This attitude must first change. It took the NGOs six years to be able to work in prison without being looked at with suspicion. Prison staff tend to only meet and see recidivists and not those prisoners who stop using drugs and now lead 'normal lives'. Therefore, they adopt the attitude 'once a drug user, always a drug user and the only solution for these people is to lock them up'. (Specialist staff, Sananim NGO, 2003)

One possibility under discussion by the General Directorate of the Prison Service is to set up a substitution centre for prisoners who were receiving substitution treatment in the community prior to being imprisoned. However, at the time of the visit, substitution treatment was not available in Czech Republic prisons at all. At Příbram prison staff were not generally in favour of substitution treatment:

giving substitution treatment is an easy way to keep prisoners on drugs and make them calmer. I have felt a lot of pressure to introduce methadone in the prison but I am not in favour of it. I am in favour of providing it for heavy drug users but not for non-heavy users. I think there are other methods such as abstinence that is better for non-heavy drug users. (Prison Director, Příbram prison 2003)

Substitution treatment in Opava prison is not offered or considered favourably; rather it is seen as a continuation of addiction. The prison environment, it is ar-

45 In the community Sdružení Podané Ruce provides substitution treatment, especially methadone. They also work in some prisons.

gued, offers a different environment from that in the community, as conditions for abstinence can be arranged in prisons. Abstinence is the key aim for drug treatment in the prison and the prison director believes that a proper drugs-free environment can be achieved (Opava prison, Director 2000). The prison director at Opava prison said that if a prisoner goes through withdrawal in prison, he is taken to the civil hospital in the community where he receives care. Buprenorphine is used at the prison hospital in Prague on a short-term basis to decrease the effects of withdrawal:

since June 2003, 40 patients have received buprenorphine. Prisoners have not reported any side effects. I am generally satisfied with the results of the treatment. Prisoners get information about the treatment and are told about detoxification. Staff in the prison are also pleased with the treatment as prisoners are quieter and more manageable. It is important to make sure that subutex is provided with high security to avoid having any available on the black market. Before providing subutex a meeting was held with all staff to evaluate how to provide subutex and what were the most suitable ways to provide it that fitted with the prison routine. The General Directorate of the Prison Service gave some financial support to the prison hospital to buy the required medication. (Psychiatrist, Prison Hospital Prague 2003)

This treatment using buprenorphine is not available at all prisons and the view of some staff from the NGOs is that withdrawal is often ignored in some prisons. As one prisoner said:

here in prison it's [ST] almost out of the question. You don't get any treatment for withdrawal, the doctors know that you can't die so they just let you crawl on the floor. Outside it's different, because you get treated in a different way, you get some substitution treatment. (Prisoner focus group, 2003)

In Hungary methadone is not available within prisons but should a prisoner require it, he/she would be taken to a community facility on a daily basis for methadone treatment. Detoxification is not available in Lithuanian prisons, nor are there methadone programmes available for prisoners.

The General Directorate of Penitentiaries in Romania has started preparations for problematic drug users within the detoxification section in Rahova prison hospital. The prison service programme for the future also involves:

- setting up a post cure pilot centre (for methadone maintenance);
- training for prison personnel;
- specialist training for medical personnel;
- training for handling special equipment for the detection of drugs (Ministry of Justice Order no. 785/2002 and Ministry of Health and Family Order no. 898/2002).

As a key part of continuing harm reduction, the Romanian Prison Service Department hopes to introduce a methadone maintenance programme, drug-free sections and needle exchange by 2005. These programmes will be developed over the next year and will provide enough time to have completed the necessary staff training (General Directorate of Penitentiaries, 2003).

There is only one methadone project in Slovakia, at The Centre for Drug Dependencies Treatment in Bratislava. There is a debate at the moment in the community about the use of buprenorphine rather than methadone and until agreement has been reached in the community methadone will not be available in the prisons (Head of Health Care, Prison Service Department 2004). At Bratislava Pre-trial Prison, if drug users arrive at the prison at weekends or in the evenings and if the security staff think they require drug services then they will contact the services in the community. Leaving members of security to make this judgement places a lot of responsibility on the staff and demands a high level of training about drug addiction. At other times it is up to the psychiatrist to decide what drug treatment a prisoner requires. There were about eight prisoners during 2002 who required detoxification (Head of Health Care, Bratislava Prison 2004). Trenčín prison hospital has a withdrawal protocol and they treat pre-trial prisoners if it is necessary. Every prisoner is examined quickly and if they have symptoms of withdrawal they will see a psychiatrist. If the symptoms are serious, the prisoner will stay at Trenčín prison hospital but otherwise they will stay in the pre-trial prison.

Summary

In summary the data in this chapter indicate that while all of the sample prisons said that they provided harm reduction information to prisoners at entry to the prison the content of the information was often minimal and not presented in a way that prisoners found accessible. This was demonstrated by some prisoners, who said in the focus group that they had not received any information on arrival at the prison despite having signed a paper saying that they had. Often it was only on arrival at the prison that prisoners did receive information because ongoing programmes that utilised more interactive means to provide harm reduction information were not available to the majority of prisoners in the prisons of the sample countries. None of the prisons in the sample had a clear strategy for the provision of harm reduction information and in some prisons this resulted in confusion amongst the staff as to who was responsible for providing such information. Often the information that was available was targeted specifically at problematic drug users and it was unclear if other prisoners received such information.

While some staff in the sample prisons thought they were well informed about drugs and communicable diseases others felt there was a need for training in this area, especially about drugs, since dealing with this issue was new for them. In addition some staff identified the need for drug specialists to be employed to work with problematic drug users.

Although it was possible to buy condoms from the prison shop in all the sample prisons they were not part of a coherent harm reduction strategy. While some staff and prisoners considered the provision of condoms to be necessary, others were more ambivalent about their provision in an all male setting and thought it was sufficient that prisoners could buy them if they wanted them or that condoms

be made available for intimate visits with heterosexual partners. Ambivalence was also shown towards the provision of bleach, where in some of the prisons it was made available to prisoners but was not accompanied by harm reduction information about using it to clean injecting equipment.

The introduction of needle exchange in prison is not yet on the agenda of any of the sample countries, although the possibility is being discussed by some of the prison administrations. Its introduction is a very political and complicated issue and is still rare in western European prisons. Attitudes amongst the majority of prison staff in the sample prisons may well change as an increasing number of problematic drug users enter their prisons and as more information and evaluation of existing needle exchanges become available.

Substitution treatment for both short and long term maintenance was available in two of the countries but not in all prisons. In both these countries NGOs were also involved in the programmes providing a bridge with community treatment services. This helped to ensure continuity of treatment after prisoners were released from prison.

Chapter 8

Drug treatment in prison

Drug strategy

The following discussion about whether the prison systems of the ten countries had a prison drug strategy (not necessarily in written form) refers to whether there were initiatives in place to meet the growing needs of problematic drug users in prison. Not all of the sample countries had a drug strategy. However, in those countries where there was not one, staff both in the prison administration and in the prisons considered one to be necessary to meet the needs of the growing number of problematic drug users coming into prison.

At the time of the visit there was no Department for Punishment Execution drug strategy in Bulgaria, but the department was currently working on one. It would appear that the push and development of a prison drug strategy was coming from the individual prisons themselves. As the director of Lovech prison said:

a prison drug strategy is not coming from the Department for Punishment Execution; drugs are a new problem for prisons and the prison is working with the NGOs that have more experience with drugs. (Director, Lovech prison, June 2003)

As the Director of Varna prison pointed out, it is important to have a drug strategy since approximately half the prisoners currently in the prison have used drugs:

as a result of this, we are going to have increasing numbers of recidivists as there is not time to change their behaviour while in prison. At the moment, recidivists are middle-aged, but now the criminals are younger, often drug users, who repeat their crimes. The prison tries to limit the drugs coming into the prison; we work with the NGOs and train security staff, as drugs are new for them. We have shown them the kinds of drugs and invited people from the community to be involved making links and co-operating with the NGOs. (Director, Varna prison, June 2003)

The importance of having a coherent prison drug strategy was also stressed by another member of staff at Varna prison who felt that:

there will gradually be more drugs getting into the prison and I am afraid that we will be dealing with the consequences rather than with the root causes of drug use. About 18 months ago, I invited a clinical psychologist to the prison and she gave a course about the symptoms of drug addiction, reacting to withdrawal and possible variations of suicidal behaviour. This was a successful start because drug addiction became a big problem two years ago. The security staff have also had similar training. The prison needs to form a

multi-disciplinary team to work with drug addicts in the prison. The problem is now urgent and the role of the NGOs – to work with drug addicts – is crucial to start to encourage others to start thinking about this problem.

In the Czech Republic, there is an official drug strategy for the Prison Service, concerning education, counselling, training and prevention of drugs, for prison staff and for the prisoners. It includes reduction of drug trafficking into prison, harm reduction, establishing drug-free wings and treatment for problematic drug-using prisoners. The specialised prison sections (for drug treatment) mostly use the same strategy that is used in the national psychiatric hospitals where problematic drug users are treated. However, there is no written strategy that everyone has to use (Prison Department, 2003).

In Estonia there was no strategy for drug treatment in prison at the time of the visit but one was being developed. There was, however, a *Prisons drug prevention strategy 2002–2012* that forms one part of *The Estonian National Drug Prevention Strategy 2002–2012*. What the prison service is currently lacking is ‘a drug prevention concept for the Estonian Prison System, that provides more exact guidelines on how to carry out the objectives and actions/activities mentioned in the *Prisons Drug Prevention Strategy 2002–2012* (Prison Department, 2003).

The National Drug Strategy is used by Tartu prison, Estonia, as a basis for its own strategy. There are the same overall objectives for all prisons and the strategy is used for both pre-trial and sentenced prisoners. The main focus is on sentenced prisoners, where problems with drug addiction can be dealt with in more depth, rather than pre-trial prisoners who are in the prison for a relatively short time. The strategy involves creating a drug-free section in the near future, addiction programmes and using a drug dog for searching the prison and during visits to keep drugs out of the prison. The drug strategy is being developed across the different disciplines in the prison. Some staff in the prison said that they were not involved in the formation of the prison drug strategy and would find it helpful to know more about it. In reality, Tartu’s prison drug strategy is a formal document rather than a working document. The prison director considers that the key task at the moment is to make the prison work and to get control of the prisoners, as this is a new prison. The control of drugs coming into the prison is considered to be effective as very few drugs are found in the prison. The prison also has two drug dogs. Tartu prison is also using drug testing as a control when prisoners return from home leave. All prisoners sign an agreement to be urine tested, but there are some cases when they refuse and they cannot be forced to comply (but this will impact on the benefits that they get). There are frequent controls using the drug dog in the sections, for searching mail and packages and for checking visitors. In addition, there is an X-ray machine that is also used for security and searching for drugs.

Viljandi prison uses the basic prison service drug prevention action plan; the only difference is that there is a drug-free unit in the prison. This is the only one in existence at the moment in Estonian prisons. The role of the drug-free unit is more about being preventative than dealing with serious addiction.

During the visit to Hungary in 2001 (MacDonald, 2002), the national prison drug strategy was more a complex of visions than a clearly formulated policy.

Now there is a strategy that encompasses new initiatives like the drug-prevention units. The new drug strategy is an integral part of the National Drug Strategy. It has been difficult until recently to produce a strategy due to constraints in the law. Hungarian drug laws are strict: where people are caught with drugs for their personal use they can receive a two-year sentence. However, if the person agrees to undergo therapy, the sentence is dropped. The law is unclear about what happens if a person is unable to undergo this treatment because of being in prison. Due to this ambiguity, the prison service developed a drug treatment course for prisoners to attend, which is equivalent to that in the community. This is provided by the Forensic Observation and Psychiatric Institute.

At the time of the visit to Latvia, there was no national drug strategy: as a consequence, the prison administration did not have a drug strategy (Prison administration, 2003). Some staff from the sample prisons considered this lack of a strategy as important:

it would be good to have one and we need drug-treatment programmes. At the moment we try to involve the drug users in school or work to fill their time. (Staff, Ilguciema prison 2003)

Staff from Parlielupes prison argued that the need for a drug strategy was growing because drug users were getting younger and more of them were ending up in prison.

Prison staff often perceived a lack of a dedicated budget as one of the principal impediments to the development of a central strategy for treating problematic drug users: 'We have started to think about programmes but we lack money, staff and the rooms to do it.' (Prison staff, Ilguciema prison 2003).

At the time of the visit, there was no formal Lithuanian prison drug strategy. The Correctional Affairs Department is involved in the National Drug Prevention Programme (Director General, Correctional Affairs Department 2003). The main component of the Correctional Affairs Department's response to drugs in prison is to control the supply of drugs getting into the prisons. In order to reduce the amount of drugs that get thrown over the prison walls, guards patrol outside the perimeter walls; staff are being checked to ensure that they are not smuggling drugs into the prison and the Parliament is considering legislation to prohibit prisoners receiving packages, as this is a key way of smuggling drugs into prison.

After it became clear that there was drug use and opiate use in Polish prisons, demonstrated by Sierosawski's (2003) study, prison staff have been trained in dealing with drug users and raising their awareness of drugs and related issues. The focus of the Central Board of the Prison Department's drug strategy has been concentrated on supply reduction and control measures (i.e. urine testing), but now also has an element of drug-demand reduction, encompassing drug-free treatment in ten therapeutic units and methadone maintenance programmes in four prisons (see section on substitution treatment above). The drug strategy in prisons is an inherent part of the National Drug Strategy and the resources necessary to implement it come from the Ministry of Justice budget. Every year, reports on the implementation of the strategy are submitted to the Ministry of Health, which coordinates the implementation of the National Drug Strategy.

The Ministry of Health and the General Directorate of Penitentiaries in Romania have a common strategy regarding educational and medical treatment for drug users in prison. The evidence that prisoners are drug users is based on the prisoners informing the prison that they use drugs. The medication that they may require is prescribed and administered in the prison. If it is necessary, any medical (emergency) treatment can be done in the public health system (CEENDPS, Partner Report 2004).

The joint project between the General Directorate of Penitentiaries and ARAS in Romania has provided training for staff and peer educators (prisoners) on HIV prevention and related risk behaviour in injecting drug use. The prison drug strategy also involves prevention, with staff being searched when they come into the prison, the searching of packages sent to prisoners and the training of staff about drugs.

At the time of the visit to Slovenia there was no formal prison drug strategy. However, drugs and alcohol are acknowledged problems in prison and the national prison administration is developing a strategy. The strategy will build on two components: the prevention of drugs coming into prisons and treatment for those prisoners who want to change their life style and stop using drugs (Head of Communication and International Affairs and Head of Health Treatment, National Prison Administration 2003). The implementation of programmes for problematic drug users will involve the Ministry of Health, the network of Centres for the Prevention and Treatment of Drug Addiction (CPTDA), the hospital for infectious diseases and its regional units, the central hospital for pulmonary diseases and its regional dispensaries, as well as non-governmental organisations.

Drug treatment

Both compulsory and voluntary treatment were available for problematic drug users in the ten countries. Compulsory treatment is that ordered by the courts and often carried out in psychiatric departments within prisons. In Hungary drug treatment that was available in the community as an alternative to custody for possession of drugs was also offered in the prison. This meant that prisoners could reduce their sentence by participating in this course. NGOs offering drug services also played a key role in the delivery of harm reduction and treatment in some prisons in most of the sample countries.

There is a range of options offered for voluntary treatment across the sample countries: the gradual introduction of drug-free zones (units) in several of the countries (often with different names), open prisons, transitional prisons, NGO projects, prison-based treatment involving individual and group work.

Bulgaria is one of the countries where drug treatment can be compulsory in prison if ordered by the courts and can continue after the end of the prisoner's sentence. Apart from this compulsory treatment set by the courts, the only other treatment for drug users is from short-term projects provided by NGOs. There are two prison hospitals for compulsory drug treatment ordered by the courts, one in Sofia and the other in Lovech prison. The treatment of drug users in Bul-

garia, both in prison and the community, is carried out mainly by psychiatrists. At Lovech prison the psychiatrist in charge of the psychiatric unit said that, although they had some drug-using prisoners with compulsory orders in the unit, in fact they did not treat them. The Head of the Psychiatric Unit who used to work with people who had a drug dependency in the community was of the opinion that:

compulsory treatment is a misunderstanding, as you can't treat people in this way. There has to be motivation on the part of the [drug] dependent. This issue is endlessly discussed, but this part of the penal code [that allows for compulsory treatment] is never discussed and there is not the political will to change it. This part of the penal code can make some prisoners resistant to change. There is also no time set by the court for the length of the treatment in the Psychiatric Unit and I, as the doctor, can't decide when the treatment is finished as this decision has to be made by the courts and this process can take months.' (Head of the Psychiatric Unit, Lovech prison, June 2003)

The staff at Lovech prison were very aware of the increasing number of drug users coming into the prison and the need to work constructively with these prisoners and to offer voluntary drug-treatment programmes. There was also an awareness of the need for staff training in how to work with drug-using prisoners:

the prisoners come to this prison after withdrawal problems so we need to support them with social, psychological and pedagogic help. Also we can support them with help from the medical and psychiatric departments. The conditions and the lack of experience of working with drug addiction is the problem; we need to help the prisoners with psychological dependence and at the same time try to prevent drugs getting into the prison. We are trying to develop ways to deal with drug addiction via individual treatment or problem solving and by putting them in a particular environment. I think it is best to put the drug-dependent prisoners together as they have a common problem and they exchange both positive and negative information and support each other. (Social Worker, Lovech prison, June 2003)

In response to the growing number of drug-using prisoners, Lovech prison have implemented and run two three-month drug programmes in conjunction with the NGO, Open Society. The prison is preparing to run one for another group soon. It is not an expensive programme and the NGOs come into the prison. Twenty-nine prisoners, aged between 19 and 25 years, attended the first two programmes. Prior to the start of the project, a team was created in the prison consisting of staff who worked both in, and out of, the prison with prisoners with dependency problems. The team consisted of the prison doctor, psychologist and social workers. The prison has a specialist unit for drug-dependent prisoners (the psychiatric unit) and the psychiatrist from this unit and other prison medical staff were very helpful during the programme. This programme is voluntary and they try to run it near the end of the prisoner's sentence. The approach, at first, was authoritative and directive, to clarify the goals of the project. At the moment, only a small number of prisoners with drug problems volunteer to participate on the programme. The staff hope that the numbers will increase with the impact of

‘peers’ who have done the course talking to other prisoners. The main principles behind the drug programme are that prisoners:

- should want to participate and be prepared to co-operate fully with the programme;
- should be near the end of their sentence;
- agree to have a full medical examination (considered to be important as the drug users usually have hepatitis and liver problems);
- should be aged between 19 and 32 (as this age-group is considered to be the most receptive to change).

The programme involved a mixture of group work and individual work with the participants. The psychologist and the social worker had two meetings with prisoners per week and the prisoners could see either of them when they wanted. In the group work the aim was to:

strive to give the prisoners ideas about different patterns of life without drugs and their former friends. A lot of the prisoners can’t write and we put them in pairs to stimulate them to improve. (Psychologist, Lovech prison, June 2003)

A range of problems was covered in the group work, for example relationships with parents, hepatitis C and how to manage this condition. The programme also covered harm reduction and prevention, communication skills and conflict resolution (in a legal way). The prison priest was involved to provide the spiritual element and a Spanish prisoner who had been in a commune for drugs came and talked with the prisoners on the programme. The idea of peer support was considered to be valuable, even if this just stimulated discussion amongst the group. The programme also had a vocational element in teaching brick-laying. The staff who were interviewed were very positive about their involvement in the drug programmes although they identified some problems. One initial problem was that the prisoners did not really understand what psychologists and social workers do; as a result some prisoners had unrealistic expectations about the help that they could provide. Drug users were seen as a difficult group to work with but the work was interesting “if we can get the drug users to respond; about 80 per cent of them want help and they respond but some believe that after withdrawal they have solved their problems” (Social worker, Lovech prison, June 2003). The social worker involved with the programme was concerned about what happens to prisoners when they leave the prison as they are not supported, especially if they have no family or friend support networks. These drug programmes have not been formally evaluated. However, after the first two programmes finished, the prison presented their findings and experiences with the programme at a conference involving the national prison administration and other prisons, as a contribution to developing a common strategy for working with drug-dependent prisoners. The results of these drug programmes are considered to be positive although it is difficult to say exactly what the results are as the prisoners who took part in the programme are still in the prison; the real results will be more obvious when the prisoners are released. As one member of staff remarked, “this course could not meet all the needs of the 100 plus drug-dependent prisoners in the

prison but it is a start". The director of the prison also considered the course to have had a positive effect on other prisoners within the prison.

At Varna prison, in Bulgaria, in 2002 there was a project for drug users called the 'New Way'. All the drug users were told about the project and invited to sign up for it if they wanted to be involved. The project lasted for eleven months and involved 41 prisoners. The drug users specifically targeted were those who had just come into prison, those who had undergone withdrawal in the pre-trial prison, wanted to stop using drugs and those who no longer saw themselves as drug addicted. The goal of the project was to teach the prisoners to say 'no' to drugs when they left the prison. The prisoners in the groups were from different social classes and ethnic groups and with varying levels of education. Prisoners signed a therapeutic contract and filled out a detailed questionnaire providing information about their closest personal contact, history of their drug abuse, any previous counselling, their medical history, and their life story. It was considered important to begin the programme with communication skills to enable the prisoners to listen to each other and to the staff. According to the head of health care, gradually the prisoners moved from initial suspicion and uncertainty to participation in the group work. The project has not been evaluated but some of the participants were in the focus group. The views of these prisoners were mixed:

- it [the drug project] was good but then the doctor [psychiatrist] became ill and wasn't here;
- on the course they talked 'bullshit';
- it provided some entertainment and passed the time.

When asked during the focus group if being on the project had made them consider not using drugs after release the response was:

all prisoners think that as they have stopped in here [prison] they will stop outside but, in reality, once outside you start again. I think the programme helped me. It would be better if we could work and be occupied. (Prisoner focus group, Varna prison, June 2003)

The prisoners in the focus group said that when they left prison they would not go to an NGO offering drug services for help because "they couldn't see how it would or could help them". This indicated a role that the prison could play in informing prisoners about what help is available in the local community and what services they offer.

Lovech prison does not have official links with any NGOs that provide services for drug users and to which prisoners could be referred at the time of release from prison. The prison director hopes that as the new probation service develops this will provide through care for prisoners. At Varna prison prisoners are being directed to the local government committee office where they can go for a range of information. The Director of Varna prison has regular meetings with local and regional government officials. The Varna region is the only region in Bulgaria that supports drug projects using regional funds. This co-operation is considered to be important as local government agencies are usually very conservative about providing services in the area of drug addiction.

At the current time in the Czech Republic, the General Directorate of the Prison Service has established drug free zones in 22 prisons (both sentenced and pre-trial prisons). The establishment of more drug-free zones in other prisons is dependent on the space available and the reconstruction required. At present there is space in drug-free zones for 938 prisoners. As well as drug-free zones there are special units in prisons intended for medical treatment and the rehabilitation of drug-dependent prisoners. These special units have specially trained professionals who correspond to the staff in similar public facilities that include pedagogues, educators, therapists and security staff (General Directorate of the Prison Service, Head of Social Work 2003).

In addition there are three prisons in the Czech Republic that have Specialised Treatment Units. These are different from the Drugs Free Zones as the focus is on therapy and treatment for drug users. These Treatment Units are located at Opava, Rynovice and Příbram prisons. The Specialised Treatment Units at Opava and Rynovice have prisoners who have volunteered to join the unit and also those sentenced by the court to be there. At Příbram prison the unit is for prisoners who volunteer to attend.

The Treatment Department at Příbram prison has two units: the Specialised Drug Treatment Unit and the Drugs Free Zone. While the focus of the Drugs Free Zone is on prisoners doing more activities, the Specialised Drug Treatment Unit focuses more on psychotherapy and support.

The Specialised Drug Treatment Unit was created in October 2002 based on an examination of how different prisons work in the country. It has twelve staff⁴⁶ with one vacant position. The unit has a capacity for 32 prisoners but at the time of the visit there were 21 in the unit. All have come on a voluntary basis and not because of a court order. Prisoners spend six to twelve months on the unit and after this they are transferred to the drug-free zone. They share a cell with four people and are unlocked all the time and can move freely around the unit and other cells. They are kept separate from the rest of the prison population and are not allowed to work in the prison. They are subject to frequent and regular drug testing and so far there have been four positive drug test results but on the whole:

prisoners are motivated not to use drugs. The environment is better than any other to give them such a motivation. If a prisoner is found to be using drugs, he is automatically transferred out of the Specialised Unit. If the prisoner doesn't fulfil the tasks that were set for him by the unit then he is also transferred. (Prison Director, Příbram prison 2003)

The prisoners on the unit are those who do not have problems with alcohol or gambling; they have used different types of drugs depending on their financial means; and their offences are linked to drug-related crimes. They will usually have used heroin and pervitin for 5–10 years. The average age of the prisoners is 23–24 years with the youngest being 20 years (Specialized Drug Treatment Unit Staff, Příbram prison, 2003). The Specialised Drug Treatment Unit receives eval-

46 The staff consists of a social worker, pedagogues, therapist, education-therapist, educators, psychologists and the head of the whole department (who is a psychologist).

uation from the prisoners on the unit but as yet no formal evaluation has been done because it was created only recently. The prisoners in the focus group made a range of comments about their experience of the unit:

the staff on the unit are making an effort, but it's more about keeping us busy and entertained so that we are not thinking about drugs. I am not sure that the unit is actually going to help me to stay off drugs after I am released.

There is one therapy focusing on drug issues; the rest are things like gardening. The regime is quite free and I would like it if it was more focused on drugs. The staff don't seem to be skilled or trained to provide drug therapy.

I am not used to just lying around all day. I like to do activities all the time and this is something that you do in this unit. Some activities are not fully developed yet and it would be good if they were developed. It's hard to say exactly what else is needed but for starters it would be nice to have advice as to what to stay away from [to remain drug free]. Also we need to talk about the beginnings of what brought us to use drugs. Those things would be nice, and also some other activities that would help people not think about drugs, but it's hard to say what the activities should be.

Being at the unit has helped me mentally, it helped me to calm down and get into some kind of mental balance which, if I was put in some other department in the prison, might be a bit more difficult. One thing I would also appreciate is some kind of pre-release education about how it's going to be after release and information on where to go, whom to contact once you get out.

The Specialised Drug Treatment Unit at Opava prison has existed for four years and according to the prison director it is one of the best in the Czech Republic. The programme of the unit is run in collaboration with the local psychiatric office. This unit gets more financial support than the rest of the prison.

The unit has prisoners with drug and alcohol problems. It is for women prisoners but a similar unit is being built for male prisoners and will have a capacity for 23 men. The programme lasts for up to 12 months and for a minimum of 6 months (for volunteers). Prisoners who are in the unit due to a court order must stay for the length of time ordered by the court. The prisoners from the focus group gave a range of views about the Specialised Drug Treatment Unit:

the staff at Opava prison give an individual approach and really try to give one to one support. I am satisfied with the psychotherapist's help that I get. They help me to talk about my experience, to make the difference between reality and what is not real, but rather imagined due to drugs. In the Specialised Drug Treatment Unit prisoners are always kept busy. I am worried about release, but while I am in prison I have the time to reflect and to sort out what I have been through. At release I will be able to go to a community centre.

It is hard to compare the unit as it is very different to other prisons. The difference with the unit here, is that you go through some kind of rehabilitation; it is kind of exceptional. Other prisons are maybe crowded or packed with people. The atmosphere here is quite different. In other prisons there are not

so many activities as we have here. Here we always have something to do, whereas somewhere else we are totally bored and out of boredom we can get crazy ideas. But it is hard to find work. I have been here for about a year and I don't have a job yet and I don't have any income.

The role of the NGO Sdružení Podané Ruce has developed in prisons and it has gradually developed a more cooperative relationship with the Prison Service. They work with five different prisons. The relationships in each prison are very different: in some prison the prison staff are very open and cooperative while in other prisons the contact is very formal. Sdružení Podané Ruce provides therapy and a group counselling programme for problematic drug users. The NGO also provides a link with drug services in the community for prisoners at the time of release from prison. In the community they provide substitution treatment, especially methadone.

The NGO SANANIM works in two prisons in Prague. Their work is mostly with pre-trial prisoners in these prisons as there is only a small section for sentenced prisoners. The work is mostly drug counselling, provision of information about harm reduction and infectious diseases, maintaining contact with families (done with the agreement of the prisoner) and, information about treatment available after-release. At the time of release the NGO provides the prisoner with a contact to a treatment facility. The work is with individual prisoners providing counselling. It tends to be difficult to provide in-depth work due to prisoners being transferred and therefore the focus is on general counselling. A worker from the NGO visits the prison alone. The activity that happens in each prison follows an agreement with the General Directorate of the Prison Service and the individual prison management. The level of cooperation in the prison still depends on key individuals, i.e. a specific psychologist or social worker in the prison who is willing to work with the NGO and wants the cooperation to be successful. The NGO continues to provide support to prisoners who were clients before their imprisonment. They also work with drug-dependent offenders, alcoholics and gamblers. The NGO hopes to expand its services and to offer group meetings with juveniles, young adults and staff.

The drug free unit at Viljandi prison in Estonia has been operational since 1999 and has ten places available and no room for expansion. The prisoners currently on the unit are 17 years or older, but there have been younger ones on the unit at other times. The aim of the unit is to show the prisoners that there is more to life than drugs and crime. This is to be achieved both by the regime offered on the drug-free unit and via a range of therapies and activities provided. To get a place on the unit, the prisoners have to apply and their application is considered by the specialist team consisting of the prison director, head of security, head of social work, psychologist and unit worker. Once a boy is accepted onto the unit he must have at least six months left of his sentence before he is due to be released from the prison. Prisoners who come onto the unit have to sign a contract to abide by the unit rules and to agree to be urine tested after returning from prison leave. Prisoners usually get 5–7 days leave at a time. If they have a positive test result when they return to the prison the sanctions are no more home leave or loss of the possibility of early release. They also have to agree to attend the therapy groups, to behave well and to look after the unit. On the unit the prisoners have therapy

three days per week organised by the psychologist. The psychologist also provides social skills training and some individual sessions with the prisoners. The groups are in Estonian and Russian as there are five Estonian and five Russian speakers on the unit. Music and art therapy are also used. In addition, short trips out of the prison are arranged as it is considered important that the prisoners remain in contact with life outside. The regime on the drug-free unit is better than in the rest of the prison: the prisoners are not locked in their room and can move around the section. They can have showers twice per week and after sports. The conditions on the unit are better than in most of the boys' homes so they like it on the unit. The prisoners can also do some cooking and they have access to more activities than others in the prison. During the focus group with prisoners from this unit, when asked if they found the therapy was useful they answered that it was more about the individual wanting to change. One of the Russian prisoners said that he had not had any therapy. The problem-solving group work was considered to be very helpful. When asked what effect being on the unit had for them the following responses were given:

- Maybe the unit opens our eyes more to other possibilities.
- It [the unit] makes a difference.
- I am sure that I will not try drugs now when I leave as I had thought about it before when I was previously drinking.
- I am not sure if this has made a difference. Maybe or maybe not I will use drugs again when I am released.
- Whether the unit works or not depends on your mindset and if you decide to you can stop using drugs and change your life. (Prisoner focus group Viljandi prison, May 2003)

There is no formal evaluation of the unit but the key worker on the unit said that she intends to ring up those who leave the prison to see how they are doing, not as a prison official but as a friend.

The NGO *Convictus*⁴⁷, who at the time of the visit were not working with the sample prisons, were working in Maardu prison where, out of the 1,700 prisoners, there are 160 prisoners who are HIV-positive. *Convictus* try to work with HIV in prison and in the community. They also work with non-HIV-positive groups about re-socialisation back into the community. They try to keep in contact with released prisoners to help with their re-socialisation.

The programme they provide in the prison is offered in Estonian and Russian, but the majority of the groups are in Russian as the majority of problematic drug users come from the Russian speaking population. On the project, they try to tell prisoners who are HIV-positive and IDUs that they have a future and if they give up drugs they may have a better chance of survival with new treatments for HIV. When the project first went into the prison, prisoners who were HIV-positive thought they were going to die anyway so there was no point in becoming drug free. Thus, the first thing the project had to do was to change prisoners' attitudes about their future.

47 The organisation is a partner with a Swiss organisation called *Family Health International* from whom they get their funding.

Overall, Convictus considered the co-operation with the prison to be good and:

we try to treat the prisoners in as humane a way as possible, like friends and as individuals. Funds are scarce and we use volunteers and specialists who have to be paid to go into the prison. The volunteers may have helped with the project when they were in prison and now they want to help others. We also use people who have been drug users but who have not been in prison. In the future we intend to use former prisoners as role models and we don't foresee this as being a problem with the prison department.

Since the visit for the research, Convictus now have a contract with the Prison Department to extend their activities into more prisons.

The Forensic Observation and Psychiatric Institute in Hungary has developed an experientially-based treatment programme for prisoners (Specialist staff, The Forensic Observation and Psychiatric Institute, 2003). The treatment for this group of problematic drug users is prescribed by law and includes in-depth analysis of the drug user, a range of tests, a two-page autobiography and then group work. The specialist team involved in the therapy includes a psychiatrist (a drug specialist), a psychologist, a pedagogue and a social worker. In addition, a sociologist and a lawyer also have some involvement with the group. Staff from the Forensic Observation and Psychiatric Institute thought that they had an advantage in working with prisoners: because they are not prison staff, they could be more sympathetic with the prisoners than prison staff. The treatment lasts for approximately six months but not all prisoners are in the prison for this long. The prisoner, if released prior to finishing the therapy, has to complete it in the community.

The Hungarian Prison Service Department has, since September 2003, had drug-prevention units available in four prisons, although initially these did not have a legal status. Legislation has only recently been established to provide legal status for such units but the prison service has had no money to put them into practice. Finance has now been made available from the National Drug Strategy and it is now possible to develop twelve more drug-prevention units in twelve prisons. Drug-prevention units allow prisoners to receive more parcels and visits and the accommodation is better. In return, prisoners have to agree to drug testing and to take part in drug prevention programmes. Programmes for the drug prevention units are provided by professional staff from the community. The Prison Service Department considered it to be important to establish drug prevention units as they are relatively cheap and easy to organise and implement. At the time of the visit there were no national standards set for the drug-prevention units. The focus of these units is, therefore, very broad: prevention rather than harm reduction.

Baracska National prison, Hungary, submitted a proposal to the Ministry of Sport, Youth and Children to create a drug-prevention unit in the prison. The prison was successful and they started the drug-free unit in November 2003. At the time of the visit there were eight applications for the unit, which has a total capacity of twelve. Although this is a small number, the director of the prison argued that numbers would gradually increase as those prisoners who attended the drug-prevention unit would act as an encouragement to other prisoners to volun-

teer to attend the unit. There was also a drug-prevention unit at Budapest Central prison. Prisoners from the unit said:

the conditions on the drug free unit are better [than elsewhere]; generally the conditions in the prison are bad. We are treated differently here and it is less overcrowded with four or six in a cell. It is also possible for non-workers to have a shower twice per week. (Prisoner focus group, Budapest Central prison 2003)

Prisoners from the focus group also thought that they were treated in a more human way on the unit and when they left they would be more prepared and ready for release and less likely to come back. One prisoner said that it had been very strange to come to the unit from the strictest regime to find that he could open a door, be freer on the unit and that this had meant a lot to him. The criteria for enrolment 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. Attendance at the unit is voluntary and prisoners receive better living conditions and the possibility of a reduced security classification. The drug-prevention units are new initiatives and according to the psychologist at Budapest Central prison they are planning to employ more psychologists and drug specialists but at the moment they are concentrating on the regulations for the operation of the unit. The prison also intends to make contact with NGOs to work in the drug prevention unit.

In Latvia the lack of a central drug policy impacts on the availability of drug treatment in prisons. Both prisoners and prison staff acknowledged the need for treatment and specialist support for problematic drug users. Prisoners often complained about the lack of support they received:

there is absolutely no help for drug users; the only response if you use drugs in the prison is that you get punished and no information about harm reduction is provided. (Prisoner, Parlielupes prison 2003)

we get told by some staff that we shouldn't have used drugs every time we had a problem. Some staff are very negative about drug users in here. (Prisoner focus group, Ilguciema prison 2003)

Staff training and the employment of drug specialists are viewed by some staff as crucial to support drug users in prison. Although there are psychiatrists in prisons, they are not trained to treat issues related to drug addiction. As a member of staff commented:

we need drug specialists at the moment to be able to work effectively with the rising number of drug using prisoners. The prison service management understands this need but doesn't do anything to get them. (Prison Staff, Parlielupes prison 2003)

Although there are no specific programmes for the treatment of drug-dependent s, the psychiatrist and other medical staff in Ilguciema prison work with prisoners on an individual basis:

there are no drug treatment programmes, but we talk to the prisoners. There are 221 drug users in the prison and the psychiatrist works with them, but not willingly, as she is not a drug specialist. (Staff, Ilguciema prison 2003)

The NGO DiaLogs have recently completed their first prison project that focused on young prisoners. They have now secured funding for a new project that will last for one year. This project will involve working with pre-trial prisoners in three Latvian prisons and Ilguciema prison will be one of the prisons. The project will also provide six other prisons with harm reduction information only. They will visit each of these prisons twice to meet the staff and to talk to prisoners. The course in the three prisons will involve six topics: HIV/AIDS, sexually transmitted diseases, hepatitis, drug use and dependence, communication and social skills and peer education. The themes of providing information, skills, motivation and resources will run through all the topics. Importantly, DiaLogs will work with the same groups of prisoners for the length of the project. This will have the benefit of providing some through care for the prisoners, because when they are released they will already know about the centre and the support available from it.

Drug treatment programmes in Lithuanian prisons are not as yet established. However, the Correctional Affairs Department are aware of the need for both drug treatment programmes and alternatives to prison for drug users:

another problem group are incarcerated drug users for whom neither treatment nor rehabilitation is available. Proper care should be assured and respective medical, social and psychological rehabilitation services provided for these people in the places of their incarceration. However this is hard to achieve because of scarce psychological and social support resources in incarceration facilities: in 2001 the staff of incarceration facilities included 309.5 officers responsible for educational work. Of them, 11 were chief inspectors for social issues and 13 were psychologists. It is obvious that they would not be able to address all the needs of the drug users. Therefore, one important task is the creation of an effective treatment and rehabilitation system in incarceration facilities. (Semenaite, 2003)

At Kaunas Juvenile pre-trial prison and Correction House in Lithuania there is not a drug use problem in the prison and the programmes they offer are mostly related to primary prevention of drug use, violence and self-harm, and to social skills and art therapy. These courses are considered to be useful to the juveniles in preparation for release and all are encouraged to take part in these programmes. If they refuse to participate then their individual worker talks to them and eventually they usually decide to participate. A drug prevention course was started two years ago at Kaunas Juvenile pre-trial prison and Correction House. A range of specialists are involved in the programme. The course is voluntary and usually has approximately ten prisoners on it. There are some group sessions but it is usually based on individual work with the prisoners. There are no drug treatment programmes in Alytus Correction House; if a prisoner asks for treatment the prison will send him to an institution where treatment is available but not many prisoners apply for treatment (Prison Director, Alytus Correction

House 2003). There is a new building in the prison and eventually it will be a rehabilitation unit. When drug-using prisoners were asked if they wanted to go to this unit, out of 300 prisoners only twenty applied. The reason given for this low number was negative peer pressure. Some specialist staff considered there to be a need for drug programmes and for drug specialists to run them. However, there is a culture amongst the prisoners not to seek help with drug addiction:

I did some research with a questionnaire regarding drug users asking if they wanted treatment. Half of the respondents didn't want treatment apart from more sports and cultural life. (Specialist Staff, Alytus Correction House 2003)

Prisoners in the focus group generally felt that there was no help for drug users in the prison and that a methadone programme was needed. Some prisoners thought that:

it is necessary to create conditions in the prison that would allow you to change your interests away from using drugs. They [the prison management] need to provide more free time activities. All the trouble in the prison is the result of boredom. (Prisoners, Alytus Correction House 2003)

At the time of the visit there were no NGOs specifically for drug addiction working in Lithuanian prisons. However, the Correctional Affairs Department was open to working with NGOs in this area.

The Central Board of the Polish Prison Department provides therapeutic units. There are 45 such units (2,266 places) for prisoners with mental illness problems, 12 units for alcohol dependency (400 places) and 10 units for drug dependency with 400 places. The therapeutic units are managed and supervised by the Penitentiary Bureau of the Central Board of the Prison Department, not by the health care service. Prisoners can be ordered by the courts to have treatment in these units or volunteer to be on the units.

One of the ten specific therapeutic units in Polish prisons for drug-dependent s is at Sluzewiec prison. These units are connected in so far as they are both working within an abstinence-oriented philosophy. The structure of the units is underpinned by the Penal Executive Code (1997§117), but there is flexibility in the working of the units in order to meet local needs and circumstances. Representatives from the ten units meet twice a year to exchange information and experiences.

The therapeutic unit at Sluzewiec prison is the only one in Warsaw and had 34 prisoners at the time of the visit. The unit sees approximately 70 prisoners over the course of a year and is for opiate and amphetamine users who have no psychiatric illnesses. The average age of the prisoners is 24 years. The unit is run by a therapeutic team consisting of a director (who is a psychologist), a nurse and another psychologist. The prisoners on the unit must be diagnosed as drug-dependent and they must have been sentenced to compulsory treatment as part of their sentence. According to the treatment team of the unit, it does not make any difference whether or not the prisoners come to the unit on a voluntary basis. Prisoners from other prisons can also attend the unit.

Withdrawal is seen as a good starting point, indicating prisoners' motivation to change their behaviour. The treatment programme is in three phases:

1. Introductory phase (approximately one month). The goal of this introductory phase is to identify and to raise awareness of the symptoms of dependency. Basic education is provided about issues relevant to drug users and a nurse gives information on HIV/AIDS, hepatitis, how to deal with withdrawal symptoms and so on. HIV testing is offered to the prisoners.
2. Phase two. Group meetings where the social and individual costs of drug use are discussed, in particular the impact on individual prisoners.
3. Phase three. A mixture of individual and advanced group work that reflects on topics like emotions, feelings of shame, anger, dealing with the nature of the illness, perspectives after release. In this phase individual treatment plans are elaborated and meetings and therapy groups with drug-dependents from outside are organised in the form of peer-groups with patients and ex-prisoners.

The unit is linked with community services that come into the prison once a week to provide individual counselling. The prison co-operates with the NGO MONAR who care for those prisoners on conditional release.

After completing six months on the therapeutic unit, prisoners return to other sections in the prison. The work of the unit has not as yet been evaluated. The unit has a waiting list until May 2005 (from November 2003); 100 persons are on the list. Originally the programme lasted one year but, since more and more prisoners now want to take advantage of the opportunity the programme presents, it has been reduced to six months.

At Montelupich prison the following procedure is applied when new drug users come into prison. Initially, the person talks to the educator about his drug history. In the first phase he will also be assessed by the medical department, as a rule in the first 3 days, but mostly the same day as admission. If there are symptoms of a severe dependency the person will either be treated in prison or in the prison hospital. The prison works closely with Kielce prison hospital that has a therapeutic unit (the waiting list for this unit was about 4 months at the time of the visit). After the detoxification phase, the prisoner can join a peer group programme led by the prison psychologist who works both in the prison and with an outside organisation called 'Formaticja'. The peer group is a mixed one with alcohol and drugs dependents. The group, which usually has twenty participants, meets once a week and the prisoners receive information about alcohol and drug use, after which they can attend an outside group organised by 'Formaticja' or they can go to another prison if they have been sentenced. The group organised by Formaticja focuses on motivation building. Some prison staff do not think this is enough. Those who are allowed to meet can meet in this or in other groups. It is not possible for all pre-trial prisoners to join this group due to juridical constraints. For these prisoners individual counselling is arranged (Director, Montelupich prison 2003).

The NGO MONAR works in 15 prisons using peer support with ex-drug users and ex-prisoners who come into the prisons.⁴⁸ The main goal of the MONAR Association programmes and activities in prisons is to provide an integrated system of social assistance to counteract drug abuse, marginalisation and social disintegration and to build a bridge between prison and the services available in the community. At the same time MONAR is providing training for prison staff in order to promote better understanding of the needs of prisoners and to make a better connection between services inside prison and those outside. This training has been carried out in the special centre for prison staff training. An agreement between MONAR and the Central Board of the Prison Department has been agreed (4/12/2003) that will allow more centralised and structured prevention and awareness training and permission to go into all prisons. The future work plan foresees:

- motivational therapy with drug users;
- provision of therapy with half of the sentence in prison and the other half in a therapeutic community.

The Slawek Foundation also works in several Polish prisons. The Foundation visits and provides support for prisoners and provides a link to services in the community after release. In the community it provides a range of services for ex-prisoners. One such service is a halfway house for prisoners who can stay there for one week, where they get help with applications, documents and papers, housing matters and so on.

In Romania, as a key part of continuing harm reduction, the Prison Service Department hopes to introduce a methadone maintenance programme, drug-free sections and needle exchange by 2005. These programmes will be developed over the next year and will provide enough time to have completed the necessary staff training (General Directorate of Penitentiaries). Currently Rahova prison offers one support group for juveniles and two groups for adult prisoners who are drug users. The three groups are run by psychologists who have had drugs, alcohol and psychotherapy training.

At Târgșor prison the psychologist runs a group for drug dealers and users that lasts for three to four months. Drug dealers⁴⁹ are easier to target and the numbers coming into prison are increasing (Specialist Staff, Târgșor prison 2004). It is difficult to maintain the same group for the duration of the programme due to the high turnover of prisoners. Last year (2003) there was also a programme for ten to twelve drug users run by a psychologist in Târgșor prison paid by an NGO.

Drug treatment can be either compulsory or voluntary in prisons in Slovakia. Article 72a of the penal code allows protective treatment to be set by the courts. This compulsory treatment is available for drugs, alcohol, sexual problems and

48 MONAR are involved in the following activities in Polish Prisons:

Design and implementation of treatment and rehabilitation programmes in co-operation with the prison/penitentiary staff, within existing specialised units for drug-addicted inmates in prisons; design and implementation of treatment and rehabilitation programmes in the community which are intended for drug-addicted inmates released from prisons, and their families.

49 Due to Romanian drug laws dealers are often drug users who may have been arrested for possession of small quantities of drugs.

gambling. As part of the National Drug Strategy, an Anti Drug Fund provides money for projects in the area of drugs and the Prison Service secured 1.5 million crowns. This money was used to improve and equip drug-free zones, to pay for test strips and mobile testing laboratories. Voluntary treatment in drug-free zones was available at both Trenčín prison and Sučany-Martin prison. In the Slovakian prison system there are a total of six drug-free zones that offer 169 places.

Ilava prison provides compulsory treatment that lasts for between ninety and one hundred and twenty days; induction and the treatment are offered again at the end of the sentence. According to the prison psychiatrist, they try to reduce the length of the compulsory treatment to as short as possible so that when they observe a change in attitude in the prisoner, they can suggest to the prisoner that he can change to voluntary treatment. This shows trust in the prisoner and makes the treatment more effective. At Bratislava prison drug addiction is not treated any differently from other addictions. It is not considered to be possible to separate drug-dependents as they have multiple addictions (Head of Health Care, Bratislava prison 2004). This compulsory treatment can continue after the end of the sentence and prisoners will be taken directly to the community facilities from the prison to finish their treatment.

Under the direction of Trenčín prison hospital there is a drug-free zone located in a separate building about ten minutes from the prison. This is a semi-open facility that caters for the lowest security category. There is a high turnover of prisoners due to their having short sentences or being released early under the terms of conditional release. The director of Trenčín prison hospital argued that the drug-free zone provided a positive experience for prisoners. He thought that this treatment offered in prison was more effective than that provided in the community:

it seems paradoxical but the key factor here [in prison] is that prisoners can't escape from the treatment whereas they can in the community. In addition the treatment in the prison is very demanding and the negative features of prison are removed on the drug-free zone i.e. prisoners feel more like human beings and this is a crucial motivational factor. A lot of the prisoners respond positively to this and open up more and present their problems. (Prison Director, Trenčín prison hospital 2004)

One prisoner from the focus group agreed with the director:

I think the results here must be better than those in the community. Those treated outside receive medicines and here a more psychological approach is used and we need to have strong will. There is a gradual build up of confidence and this will help us to stay away from drugs when we leave the prison. If we are full of energy here and don't know what to do, we can go to the gym and attend the various lectures and sessions to consider our problems, if we have any. Usually we are very busy as we don't have much free time to think about things like drugs. It was hard at Christmas being in prison for 3 weeks holidays with no activities organised. (Prisoner focus group, Trenčín prison DFZ 2004)

The concept of drug-free zones is just beginning to develop in Slovakia. The decision to put a drug-free zone at Trenčín was because the prison had a specialist

staff base that could train and help those working in the drug-free zone. In order to attend the drug-free zone (DFZ) prisoners have to have an addiction, agree to the rules (for example compulsory attendance at courses, giving urine samples) and sign a contract. As the prisoners often underestimate their problems of dependency, the approach used is to motivate them to co-operate. In order to establish barriers against drug use in the DFZ, control mechanisms have been established such as breath tests to identify alcohol, urine tests and sniffer dogs and as yet no drugs have been found. Prisoners in the focus group were very enthusiastic about the DFZ and the overall conditions in the facility:

To come here is good as we can contact our families. It is possible to get drugs here but we have to control ourselves. The fence is only one metre high here but in reality it is five metres high. In other prisons you don't care a lot about the rules but here you do as you risk losing a lot if you do break the rules.

We are informed about the rules and regulations and when we do wrong we lose the trust of the managers and it is difficult to get it back again, so we mind the rules as I know that I am responsible for my behaviour not the managers and I came here on voluntary basis.

Compared to other prisons this open facility is the smallest and the best. The food is not so good. We can buy food and get a parcel once per month. We can have phone calls when we want and this is really good. After three p.m. we can wear civilian clothes. It is good that there are no security guards here when we go to work as to have this trust raises our self-esteem.

Although there is no formal evaluation of the drug-free zone, prisoners often write letters when they leave to say what they are doing and this provides some feedback.

Voluntary treatment for addictions is also available at Sučany–Martin prison and so far 200 prisoners have attended the unit. The DFZ has been in existence for the last five years. The structure of the programme offered and the staff have changed during this time. The key staff involved with the programme are a pedagogue, educators, psychologist, psychiatrist and the education staff. Attendance at this DFZ is voluntary and many drug users in the prison do not want to come to this programme as it is a new initiative and the prisoners are unsure what it will consist of. The unit officially is for ten boys but this number, on occasions, can be higher or lower. This relatively small group size is considered important as more psychological therapy can be achieved with the boys. The boys on the unit have a number of dependencies: one third are dependent on alcohol and solvent abuse, and the remaining two thirds are dependent on a mixture of alcohol with various drugs (marijuana, cocaine, LSD, heroin and other chemicals). Prisoners who come to this unit have to have a basic standard of literacy as the programme demands that they are able to read and write. The regime of the unit is very structured with a planned routine for each day. The focus is on keeping the unit tidy, clean and orderly like in a family. Overall prisoners from the focus group appreciated the programme (although did not like having to iron their own clothes). One prisoner said:

the unit is not like I expected it to be. In fact it is better than what I was expecting. It is sometimes hard to be here. When I return to my community it will be difficult not to go back to drugs but while here I have learned that it helps to be occupied and to have a successful day, to have achieved something. (Prisoner focus group, Sučany–Martin prison 2004)

The programme was evaluated by the social workers at the district offices in the community via a questionnaire. Eighty per cent of the questionnaires were returned and 24 per cent of the juveniles were either continuing treatment in the community, not using drugs or studying. Staff working on the unit raised their concerns about the continuing financial support that the programme required now that the initial funding from the PHARE programme had ended.

At the time of the visit, NGOs offering services for problematic drug users were not involved with providing treatment for problematic drug users in prison although the NGO Odysseus had some initial discussions with the head of health care at the Prison Service Headquarters in Bratislava.

In Slovenia the low threshold treatment available is a detoxification programme that includes a gradual reduction of therapy (medicine or methadone), control of one's psychological condition and checks by urine tests. The psychological assistance provided comprises motivation and support programmes when establishing abstinence and stimulation for promotion to high threshold programmes. The ultimate forms are Drug-Free Units where prisoners learn how to master their living situation, to overcome troubles and to acquire an active lifestyle (Head of Treatment, National Prison Administration 2003). The underlying principle of the high threshold programme of the Drug Free Units (DFU) is that the individual must first decide to live without drugs. Admittance to the DFU involves a medical check up and urine testing to check that the prisoner is not using drugs. Prisoners on the DFU should work either in the workshops or in employment and participate in free time activities and in education programmes (within or outside the prison). The high threshold programme will involve restoring and maintaining contacts with family members, provide the possibility for home leave, becoming familiar with NGO programmes and participating in them during the sentence, and planning for release.

Drug Free Units are available at the moment in four prisons with one of them in the only female prison in the country. Women prisoners with drug problems receive assistance in the low threshold level within a closed regime of the department in the prison. With psychosocial support from the staff they can limit and eventually stop their drug taking which can bring them to the semi-open and open regime of the prison. According to the strategy two other prisons (Maribor and Koper) are preparing for the establishment of Drug Free Units.

Drug therapy and the Drug Free Unit were discussed at length by prisoners in the focus group at Dob prison and gave rise to a range of views:

I was in the group for two months, and then I relapsed. The problem with this unit is that when you relapse you would expect the team to want to talk to you about the problem, why it happened, how it happened, how it could be prevented in the future. But instead you get excluded from the group for a mini-

mum of two months. During these two months I started using drugs again, and that was it. You start to feel bitter toward this group. Again you're shut up within yourself, and you lose trust. Personally, I respond to my environment and if there are drugs around me I find it difficult to resist. I asked to be transferred from this surrounding, I asked to be transferred to the Drug Free Unit, and when I asked for it, I was invited to the group, but they said no to the Drug Free Unit. To be transferred to the Drug Free Unit, I have to be a member of the programme and to be clean for three months. This is a precondition.

Staff in the prison also suggested that it was difficult for prisoners not to use drugs in the prison as, due to overcrowding, prisoners were mixed, with drug users and non-drug users often being put together. This makes it harder for prisoners to meet the precondition to be drug-free before being accepted onto the Drug Free Unit. Other prisoners from the focus group felt that the Drug-Free Unit should not be used as a prevention measure:

I think the Drug Free Unit should be just for people who have problems with drugs. You always meet people who just want to be on the unit for prevention and who think people who use drugs are bad. There's so much confrontation in this situation.

At Ljubljana prison where there is not a Drug Free Unit some prisoners in the focus group had negative experiences of the drug treatment offered:

most times what happens here is when you're sentenced, there's a court order for your treatment inside the prison facility. I don't know what kind of issues they have about treatments. I know if you're on methadone, they systematically lower you down [reduce the dose]. And that's it. And one day, you are without, and that's it. So whatever happens after that, it's more or less your own problem. I stopped methadone over a year ago, and in that time I was given a urine test and tested positive. The only thing that happened to me was the sanctions, like solitary, or I wouldn't be allowed to work or whatever. There is no help after that, only sanctions. Everyone looks at you like you're a worthless person because you're a drug abuser. When you prove them right all they do is punish you, nobody helps you. (Prisoner focus group, Ljubljana prison 2003)

The NGO Association for Harm Reduction 'Stigma' visit drug users in prison who were previously their clients in the community and also prisoners they have not previously met. They visit prisons twice per week and provide harm reduction leaflets to the prisoners and they would like to provide a needle exchange but this is not currently allowed within prisons. Their prison work is mainly at Ljubljana prison for two hours, twice per week. They organise some meetings on request in other prisons as well; for example, one member of staff works in Ig prison twice per month. One of the difficulties working in the prison, they identified, is that some prisoners do not want to meet them. They feel this reluctance could be overcome if they were able to move freely about the prison and thus able to talk directly to the prisoners.

Summary

A number of key points have been raised by the discussion of the drug treatment available in the ten countries. In countries where there was a developed National Drug Strategy there was more likely to be a prison administration Drug Strategy. Individual prisons in some of the countries where there was not a national prison drug strategy tended to focus on supply reduction rather than on demand reduction (with the emphasis on harm reduction and treatment programmes) for problematic drug users.

The availability of treatment programmes for problematic drug users depended on the availability of funding, trained staff and partnership with NGOs providing drug services in the community. Treatment for problematic drug users, while available in some countries, was not always available in all prisons and was rarely available for pre-trial prisoners. Short-term projects were offered in some prisons by NGOs. After the end of the projects, all activities that had been provided by the NGOs ceased. This indicates a need for the national prison administrations to make a commitment to provide assistance to enable the 'learning' from such projects to continue, either by staff training or by providing financial support to NGOs providing such projects. Many of the activities initiated by NGO projects, for example prison staff training, would not be expensive for prison administrations to continue financing. In some countries existing staff, after additional training, were offering drug therapy and this was found to be cost effective.

Chapter 9

Prison staff

Multi-disciplinary working

Effective work with drug users requires a holistic approach as it is very rare to find that drug users who are experiencing problems are doing so as a result of a single issue. It is usually the case that they are having problems in a number of areas in their lives.

There should be joint, multi-disciplinary decision-making relating to the care and welfare of prisoners experiencing social, emotional or behavioural difficulties.

Accordingly, it is important that professionals with a range of different expertise are involved in assessing and supporting the needs of prisoners. It is crucial, however, that the approach to multidisciplinary working is well co-ordinated and managed.

The management of multi-disciplinary working requires a range of key factors to be considered and addressed, including leadership enabling joint decision-making and conflict-management. The issues to be tackled require clear definition and identification. This can be achieved through a shared approach to the assessment of drug-using prisoners' needs and multidisciplinary models of service delivery. It is important that multi-disciplinary teams are well planned and founded on clear understandings relating to roles, responsibilities, boundaries, duration and resource issues. Clear mechanisms for dispute resolution are necessary. Participants are required to be committed to agreed goals, which must be achievable and regularly reviewed. In the area of drugs in the prison context, the Council of Europe (2002:116) recognise:

that health professionals alone cannot tackle the problems of drugs in the prison context. A multi-disciplinary approach is necessary. For example, people misusing drugs may need help in the form of counselling, information and education, and assistance with housing, learning, employment and finance issues on release. There is a need for prison managers and officers to ensure that appropriate security measures are in place to minimise the possibility of drugs getting into prison. (Council of Europe, 2002:116)

In the two sample prisons in Bulgaria the extent of and effectiveness of multi-disciplinary work with drug using prisoners was variable. At Lovech prison multi-disciplinary teamwork operates at the assessment unit for new prisoners. The team that deals with new prisoners includes the psychologist, doctor, social worker and the person responsible for the legal implications of the prisoner's sentence. This group studies each prisoner and the problems faced by each in adapting to prison life. New prisoners stay between 14 and 30 days in this sepa-

rate unit and during this time the specialist group prepare the prisoners' programme. The psychologist at Lovech prison said that there was room for improvement in multi-disciplinary working as:

there is some conflict between the different professions over power. I think we need to touch base to discuss different ways of working together to improve multi-disciplinary working. We need to challenge our practice now that practices in prison have changed and liberalised. (Psychologist, Lovech prison, June 2003)

The director of Varna prison considered multi-disciplinary working to be the main principle of the Bulgarian prison system while at the same time allowing for an individual approach. The psychologist in the prison thought that there were:

good relations between the specialist staff and it is improving. The philosophy about how to treat prisoners has changed a lot as more highly qualified professionals are working in the prison and this has raised the standards of treatment. The job involves mostly teamwork (the team also involves members of security, especially the inspector of the guards), as we have to meet in order to write the individual reports for the prisoners, especially those with life sentences. (Psychologist, Varna prison, June 2003)

The head of security in Varna prison also considered the relationships with the specialist staff to be good and that this was important as it would be impossible to do the job without this co-operation.

In Estonia at Viljandi prison the director felt that there is multi-disciplinary working but that they could always do better:

although the staff try to work well together there are some problems as the specialist staff receive better pay than the guards and the guards don't see why the specialists are needed, nor do they appreciate that the specialists have higher educational qualifications. (Prison Director, Viljandi prison: May 2003)

Some specialist staff in the prison echoed the director's view that co-operation between the professional staff was quite good but there were some differences of opinion regarding security issues and the activities that the specialist staff arranged for the prisoners. However, co-operation between security staff and specialists was thought to be improving because there had been some joint training courses that enabled them to get to know each other. Some staff also thought that although there was some co-operation between the professionals there were also some problems with teamwork.

In Tartu prison some heads of department felt that there was good multi-disciplinary working as one head noted:

I am not aware of any problems and I feel that the medical department works in a multi-disciplinary way with the social work department. Also with all other departments as well as we have to work in close co-operation. Heads of

departments have had training to help the process of working in this way and the heads then spread this to others in their departments. (Head of department, Tartu prison: May 2003.)

Working relations with security staff have been helped as the inspectors, guards and specialists are allocated to particular sections in the prison so they get to know each other and they have to work together. The introduction of the 'contact person'⁵⁰ has also helped to integrate security and specialist staff where the contact person provides feedback for the professionals from the prisoners. The head of health care (Tartu prison, May 2003) felt that there was multi-disciplinary working and that:

this works well, especially with the psychologists but less so with the social workers – it is ok but it could be improved. The contact with security is not particularly close but it is ok and we don't bother each other.

Staff at Baracska National prison in Hungary considered there to be co-operation between the departments as they share a common task to work with prisoners. For example, all heads of department meet each morning. There is also basic training for all staff in the main tasks of the prison and in this way staff learn what happens in each department. However there can be some conflict:

yes, there is conflict, of course, but there is a list of priorities: security, provisions of health and to utilise the budget correctly. Everything is regulated but we can decide on the way to implement the regulations. Educators are not security staff but they know that this is a prison and that security is paramount. There are conflicts and they are manageable and if it can't be decided then an order will be given. (Prison Staff, Baracska National prison 2003)

In Latvia staff from both sample prisons considered that they worked in a multi-disciplinary way with a variety of staff in the prison. In Ilguciema prison multi-disciplinary working was considered to be effective, but that there were sometimes disagreements. Normally, this kind of working was between the specialist staff, but on occasions security staff were also included. As the deputy director from Ilguciema prison said:

we work in this way [multi-disciplinary] as we can't survive if we don't. Each morning at 8.30 we have a meeting with representatives from each department and we discuss the current issues for the day or if there have been violent incidents and so on.

Other staff members commented:

we co-operate with the medical department and try to co-operate with all other departments, especially the psychologist and the chaplain. We all have one common goal – to help prisoners to adapt to prison and then to life outside. (Staff, Ilguciema prison 2003)

50 See chapter 4 for details of the role of contact staff.

One strategy adopted in Ilguciema prison to foster good working relations is to run a course of lectures, held every Friday, about legislative change, laws, reports from foreign countries and so on. These lectures are for all staff with military rank and provide a venue for staff to share ideas.

The director of Pārlielupes prison feels that they work in a multi-disciplinary way, especially as he has a small staff group who meet every morning. One member of staff was somewhat concerned that there may be too many people at this meeting and that if the numbers were reduced the group would be more effective. Currently there are fourteen members of staff who attend these meetings. Some staff considered there to be good teamwork, demonstrated particularly by the co-operation between medical and security staff:

if drugs come over the wall we [security] ask the medical staff if any prisoners show signs of drug use. This co-operation helps us in trying to prevent drugs being used in the prison. (Staff, Pārlielupes prison 2003)

In Lithuania at Kaunas Juvenile pre-trial prison and Correction House most staff considered there to be good relationships and effective multi-disciplinary working. The programmes organised for the prisoners are provided by a range of specialist staff who work closely together. Unusually in the prison setting, the health care division is key in the development and organising of these programmes. The director of the prison is keen to foster multi-disciplinary working amongst the staff.

Relations between the specialist staff at Alytus Correction House were considered to be generally good, although there were some disagreements between security staff and the specialist staff. Most of the staff in the prison are uniformed and this was considered to help in creating good professional relationships. The prison holds regular staff training and all staff participate and this again helps to foster good relationships between staff.

Although staff from the General Directorate of Penitentiaries in Romania recognised that it was necessary for there to be good co-operation between security and specialist staff within the prisons, they also recognised that there were different priorities amongst the staff that could make this difficult (General Directorate of Penitentiaries, 2004). The director of Rahova prison felt that multi-disciplinary working was necessary in order to work effectively. Although there was no training for staff in this area, staff learned to work in this way due to necessity.

At Târgșor prison effective multi-disciplinary working was considered to depend on the senior management of the prison. If the co-operation between the top managers is seen to be done well, then other staff will do the same. In the prison the staff:

are of a similar age and get on well together so there is no problem. All the staff work well together to make the prison function well. A multi-disciplinary way of working is effective as the guards know the prisoners in more depth and medical staff know medical facts and so on. (Specialist Staff, Târgșor prison 2004)

According to the director of Trenčín prison hospital in Slovakia, effective multi-disciplinary working depends on personality and in the prison there is good co-operation between those who are more empathetic. The director would:

like to change staff training and to launch an educational system for staff on the psychological side of mental disorders of prisoners. This idea is being considered at the national level. (Prison Director, Trenčín prison 2004)

At Sučany-Martin prison the heads of each department have had a range of experiences of difficult prisons and positions. The director sees the key role of these managers as being to stress the need to work well together as a team. In the voluntary drug free zone:

all work is based on teamwork and the team here has been shaped over many years. Every morning we sit together and prepare the programme for the day and all prisoners are assessed by the whole team and the group will find a common solution. The regime staff [security] are also members of the team and they have been specially selected. However, there are some problems with colleagues who are not working in this area in the prison. (Head of Drug Free Zone, Sučany–Martin prison 2004)

Staff from both the sample prisons in Slovenia considered that they had good team working practices in place. At Ljubljana prison:

those [members of security] working in the prison have to collaborate closely with the treatment team. There is good understanding and although the main job of the security staff is security, they also play a role in the treatment team. One guard representative attends the meeting with the expert team (including the doctor) and provides feedback about the prisoner. (Head of Security, Ljubljana prison, 2003)

The treatment team at Dob prison is made up of two therapists, a psychotherapist, a psychologist, a social worker, a pedagogue, the head of the group (pedagogue) and the head of guards. The team meets every morning to discuss what has happened the previous day. There are procedures in place that facilitate the relationships between the treatment team, medical staff and security, for example:

communication with the guards and the work area (employees from outside the prison service) takes place during meetings, as two members from the guards from different sections and the head of the guards of that section take part in regular meetings. The issues discussed are any problem or conflict that may have arisen. The chief of that section makes sure that the information is well shared and that relevant information is passed to the treatment team. (Head of Security, Dob prison 2003)

Training

People are required to have a high level of qualifications to work within the Department for Punishment Execution in Bulgaria and there are a lot of candidates for the jobs: 55 per cent of those who apply are rejected. The salary of the guards is equal to that of the police and there is no problem recruiting staff. The job is becoming more prestigious since the end of communism, as the Department for Punishment Execution has been de-militarised and now in the prisons it is only security staff who wear uniforms.

At Lovech prison in the previous year (2003) there was training for the guards about drugs. Social workers and higher levels of staff have also had this training. Some staff that were interviewed said that they had not received training about communicable diseases or drug awareness. This area of training was considered to be important, especially as there are more drug-dependent prisoners coming into the prison.

At Varna prison the previous doctor, who was a drug specialist, had provided some training on drugs for staff. Most staff felt that there was a need for training in the areas of drugs as hardly anyone in the prison had much experience, drugs being a new problem for prisons.

In the Czech Republic the General Directorate of the Prison Service provides a new programme for staff called 'Life long education' whereby all prison staff are offered training throughout their career. It is carried out and managed by the Institute of Education. Every staff member is required to go through at least one training course. At Příbram prison, staff also do individual studies within their specialised field. The management of Příbram prison also encourages staff to finish their education (e.g. university) and to publish articles in magazines as a means of exchanging information with other prisons. All prison staff must go through induction training. During this period they receive lectures on the law and legal regulations and sub-regulations relevant to prison, security issues and social communication with prisoners. Social communication is considered to be very important, especially for security staff, who often have a high school diploma or have done very technical studies. The emphasis is placed on psychology, pedagogy, the minimum skills needed for crisis situations and dealing with people. In addition, staff working within specialised units in the prisons go through specialised training, focusing on skills to deal with prisoners, including assertiveness, knowledge of drugs (terminology, definition), and communication (General Directorate of the Prison Service, 2003).

At Příbram prison, there is a team of lecturers providing information on specific issues, as requested by the staff. The prison director considers the calibre of the staff in the prison to be excellent:

especially compared to that prior to 1989. Before 1989 the education offered to prison staff was only the induction course, whereas today it is a life-long process. (Prison Director Příbram prison, 2003)

Some specialist staff considered there to be a lack of support offered by the prison:

colleagues help each other, but there is a lack of supervision. Supervision is currently provided once every 6 months, which is not sufficient. Support and advice would be welcome. I could do with getting some support, but not from a person from outside because they would not know how the prison works and would not be helpful. (Specialist Staff, Opava prison 2003)

Training and information on drugs, drug use and communicable diseases are offered during the induction period to members of security. At Příbram prison staff are considered to be well trained about what to do in case there is a problem or emergency with prisoners self-harming.

In Estonia security personnel must have secondary school education. The basic training for security personnel is ten months and involves attendance at college and on the job training. However it is not always easy for staff to attend the training at college.

In Viljandi prison it was considered to be hard to send the guards for training as they have families and it is difficult for them to be away from home for long periods of time. Although there is some training available in the prison, this was not considered to be adequate if they could not go to training college and it was the only training they had. In the prison there is a high turnover of guards who, after they are trained, tend to leave, either due to the low salaries or due to a misdemeanor. As the deputy director said, 'the guards' salary is about half the average salary in Estonia. Being a guard is not a popular job with the only benefit being a free uniform'. Currently the prison has two vacancies for guards. There are women guards in the prison who make up one quarter (10 out of 40) of the guards but they usually work in support roles at the gate and on the perimeter.

There is a prison trainer who provides a range of courses. All the guards and most of the specialist staff have had training on drugs provided by a drug specialist.

In Tartu prison the majority of the prison staff are new. About 50 per cent of the whole prison staff is female and 30 per cent of uniform staff is female. The prison director felt that if the salary was higher it would be possible to recruit more men. There are forty vacancies for guards, but the director felt that if there was more efficient organisation in the prison he wouldn't need them and then he could raise existing salaries.

In Tartu prison training for guards on recognising the symptoms and signs of drug use has been prioritised and most of the guards have now been trained on this subject.

Increasing the professionalism of prison staff has a key role in the reform of the prison system in Latvia. Everyone new in the job undergoes three months of basic training at the staff training centre. Further training and refresher courses are organised for staff periodically. Higher vocational training is available from the prison service college at the Police Academy and further academic qualifications may be pursued by those having completed the full course at this or other

higher education institutions (Director General, 2002) It is also possible to do a degree part-time at the prison college while working in prison. The prison administration will pay half of the cost, but staff need to contract to work for five years in prison after finishing their study.

The medical staff provide training, in the sample prisons, on HIV and other communicable diseases. Additionally, the AIDS Prevention Centre provides some occasional training.

In Lithuania staff training is a priority for the Correctional Affairs Department and a range of training is being organised to complement the re-organisation of the prisons (Director General, Correctional Affairs Department 2003). At Alytus Correction House there are a lot of new young staff and the Correctional Affairs Department provides constant training, but there is also a lack of time and finances to release all staff for training.

Each year in Poland there is a meeting of all fifteen regional heads of health care, doctors and nurses working in the prisons. One purpose of this meeting is to provide training and the sharing of experiences and ideas about the provision of health care in prisons.

The main prison staff training centre is in Kalisz. All new recruits to the Central Board of the Prison Department attend training here. At first:

they attend an intensive initial training course lasting three weeks, which gives them basic knowledge about the prison service, the profession of being a member of the prison staff and prison practice. The first two years of the career of a member of the prison staff is a probationary period during which their physical and mental suitability for the job is monitored and assessed. (Walmsley, 2003:406)

The deputy director of Târgșor Prison in Romania thought there had not been enough training about drugs. He thought that staff were better informed about communicable diseases than previously due to both information provided by the media and training.

Specialist staff at Târgșor prison felt that it would have been helpful to have had some induction training prior to starting work in the prison. They also would like to have the opportunity to meet others working in the same area from other prisons to exchange ideas and ways of working.

All prison staff in Slovakia must have completed secondary education. The initial guard training is eighteen weeks long, with alternate weeks working in prison. After this initial training staff then have specialised training. There is also yearly training of three or four days. New staff working in the prisons are mentored by older more experienced staff (Prison Service Department). Continuing education is a possibility for staff as the education system is free and in certain cases staff can be released from work and receive travel costs to attend courses. Members of staff who receive this support have to agree to stay in the prison service for a set amount of time afterwards.

In Slovenia programmes for raising awareness and the prevention of infectious diseases intended for prisoners and prison staff are provided through lec-

tures by doctor-specialists and by distributing leaflets. (Head of Treatment, National Prison Administration 2003)

Staff at Ljubljana prison had a range of views about the provision of training they received:

training for staff was provided at first, especially in '96-'99 when drug problems increased. Since 2000 we have had much less. In 2002 there was one seminar on methadone. There is no induction training provided for the staff compared to prisoners, who get an individual induction from the pedagogue within the first 4 days of imprisonment! (Specialist Staff, Ljubljana prison 2003)

Nursing staff in the prison considered they were well trained about methadone and had received training from the Addiction Centre:

the medical team from the Addiction Centre acts as supervisors. As Slovenia is a small country it is easy to meet colleagues regularly. (Nurse, Ljubljana prison 2003)

Other staff felt that too little training is provided about working in prison and that more education is needed for the security staff on drug dependency, sexual abuse and alcohol, as they have some knowledge about it, but they don't know enough (Staff, Ljubljana prison 2003).

The general view amongst the staff at Dob prison was that there was a need for more training. One group commented that, although training is ongoing it is not regular, and that more training, particularly in specialised fields, was necessary. Another member of staff, who thought that there was a need for more training, also commented that, due to a lack of staff, it would be difficult to attend training. As one group mentioned:

it is important to be informed, but also to be trained on the challenges the prison environment offers. Discussions with other staff in other prisons can be interesting even though prisons differ so much from one another that it may not be all that helpful. Each member of staff gets counselling from one another. We get more support from one another than from outside. (Specialised Staff, Dob prison 2003)

Staff welfare

There is no official staff welfare programme for staff in Bulgarian prisons and, as the Director of Lovech prison remarked, the serious financial crisis in the prison system limits the services that the prison can provide. The Department for Punishment Execution has two vacation homes, one by the sea and one in the mountains; these are cheap to use and the staff can go there with their families. Staff can also use the services of the prison psychologists and some staff have done so. Some staff use the prison psychiatrist for themselves and their families and this

service is also free. There is also some training provided for the guards about dealing with conflict in large or small groups using real case studies. Similarly, at Varna prison, staff can use the prison psychologist, but only a few guards seek this help. Those who do so are usually the new guards or those who are very stressed.

Similarly, prison staff in the Czech Republic can use the prison psychologist for support if necessary. In addition, the General Directorate of the Prison Service offers rehabilitation for staff, who can stay in a rehabilitation centre for two weeks for medical treatment and relaxation and a change of environment. According to security staff at Opava prison, in general they feel that they need more psychological support.

Neither of the prisons visited in Estonia had a formalised system of staff welfare. Prison staff can approach the prison psychologist and they get their medical care from the community.

There is no standard policy for staff welfare in Latvian prisons. There is medical care provided for military staff, but housing is not provided. Prison staff have a free medical check-up each year and the prison administration has a rehabilitation centre for staff.

In Lithuania there is no formalised staff welfare programme. At Kaunas Juvenile pre-trial prison and Correction House the staff can talk to each other for support. The prison director thought it would be good to have more female staff to make the prison a more normal environment. At Alytus Correction House the staff can use the prison psychologist. One member of staff thought:

if you compare the amount of attention given to prisoners to that given to staff then there is not much provision for staff. Although our work is stressful we are often ignored by NGOs, Correctional Affairs Department and international organisations. The job is hard, being in constant contact with prisoners, and some staff really suffer from stress. (Prison staff, Alytus Correction House, 2003)

In Poland the Central Board of the Prison Department has at its disposal 15 holiday and training centres that are located in the mountains, seaside and in the Polish Lake District. The Central Board of the Prison Department also provides free medical care for staff.

The General Directorate of Penitentiaries in Romania has some flats available for staff. Prison staff also have medical care provided by the prison where they are working.

Staff in Slovakian prisons have six weeks holiday per year and, after a certain amount of service, they are eligible for rehabilitation and an extra seven days holidays if they work in stressful conditions. They can also receive financial rewards (an extra 1 or 2 months salary) depending on the budget. The Prison Service tries to provide housing and last year (2003) sixteen flats were offered to staff. Housing for staff is not very easy to provide nowadays. There are two rehabilitation spa facilities available that staff can use for holidays. Health care is provided for staff in each prison (usually a separate GP and equipment).

Summary

While multi-disciplinary working was recognised to be both important and vital in the delivery of services to prisoners in the majority of the sample prisons, there was limited training provided for staff to make this possible. Teamwork most often occurred between specialist staff and usually did not include medical and security staff. One problem that was cited was the different priorities of security staff and specialist staff that could lead to difficulties in a multi-disciplinary approach. In some prisons where multi-disciplinary working was happening, staff commented that this had led to better working relations between specialist and security staff. Multi-disciplinary working appears to work best in prisons where there is clear support for this approach from higher management.

In all the sample countries staff training was highlighted as important, especially for the continuing development of the prison system. The extent of the training available was variable, with some prison systems mainly providing initial training and induction and others offering 'life long' training opportunities for staff throughout their career. A lot of staff thought that they needed more training about drugs and communicable diseases, due to the increasing number of problem drug users coming into prison. Some specialist staff felt that they would benefit from an induction period before they started working in prison or a mentoring system for new staff. In some prisons staff said that, due to staff shortages and overcrowding, it could be difficult to attend training events.

In the majority of the countries there was no clear policy for staff welfare. Free medical care was provided for staff in some countries or staff were able to use the provision in the prisons where they were working. Most countries provided some holiday centres (rehabilitation) that prison staff could use with their families.

Chapter 10

Conclusion and suggestions

Conclusions

The problems that confront the prison services of central and eastern Europe are shared with prison services across Europe. The sample countries are experiencing increasing drug use in the community and this is reflected in the prison population. There is an increasing number of drug-using prisoners and, in some prisons in most of the countries, drug use occurs that may involve risk behaviour. The increasing number of problematic drug users both in the community and in prisons brings with it a higher prevalence of hepatitis and HIV and other drug related health risks.

This study has identified a range of good practice and new initiatives operating within the sample prisons in the provision of both health care and services for problematic drug users. These initiatives are provided by the prison administrations or NGOs or by the prison administrations in partnership with NGOs. Overall, however, there is little standardisation in approach within individual countries: much of the work undertaken has tended to be at the level of the individual initiative rather than a co-ordinated, national programme.

Human rights principles require that prisoners should receive health care at least equivalent to that available for the outside population. However, staff shortages in some prisons make it difficult to ensure equivalence of health care. In some of the sample countries, the budget for health care was not considered to be adequate to meet all the health needs of the prison population.

The prison administrations are at different stages in developing a clear understanding of the importance of prisoner confidentiality. Confidentiality is difficult to ensure in the prison environment and the sample prisons achieved prisoner confidentiality to varying degrees. While some prisons have instigated policies to increase confidentiality, others still need to make further improvements to meet the WHO Guidelines that state that 'information on the health status and medical treatment of prisoners is confidential' and can only be disclosed by medical staff with the prisoner's consent or where 'warranted to ensure the safety and well-being of prisoners and staff, applying to the disclosure the same principles as generally applied in the community' [WHO Guidelines 31, 32].

Other aspects of prisoner culture are being addressed with varying success by the prison services, most notably bullying. In all of the countries, the policy was that bullying was not tolerated. However, there was not always a clear anti-bullying strategy in place. In order to tackle bullying effectively there is a need for a 'whole prison' approach where all staff and prisoners show a commitment to re-

duce and prevent bullying and are aware of the prison anti-bullying strategies. This supports Mills' argument that anti-bullying policies need to:

identify the circumstances that are conducive to bullying, constantly reinforcing the strategy to prisoners as soon as they enter an establishment, and challenging bullies and supporting victims of bullying in an effort to change the prison culture. (Mills, 2004)

Bullying and forced sex can also be linked to the existence of the prisoner hierarchy and here the response of prison services has been varied. In some prison services, positive action was being taken to decrease the power of the prisoner hierarchy. In others there was an attitude that there was very little that could be done about bullying and sex amongst prisoners in large rooms at night when doors were locked and there was a limited number of staff on duty. This is an area that demands attention especially in juvenile prisons where prisoners as young as sixteen are potentially at risk.

Prisons contain people who are particularly vulnerable to self-harm, and the environment itself can contribute to people self-harming. Although the majority of the sample countries reported that the incidence of self-harm had reduced since the changes in 1989 recording practices were not always clear. Research is needed to provide a more comprehensive picture of the extent of self-harm in prisons in the region. The study identified that the majority of staff working in the sample prisons considered self-harm as being manipulative. This supports Liebling's argument that such attitudes:

may lead staff to dismiss the severity of the prisoners' distress and they may be treated with contempt and disapproval rather than support and help. Viewing these acts as attention seeking or manipulation tends to ignore the real problems that motivate prisoners to commit self-destructive acts, and if there is no response to an act of self-harm, suicide may ensue. (Liebling, 2001)

A combination of staff shortages, lack of staff continuity, insufficient training and lack of information sharing can all impair the ability of staff to identify and care for prisoners at risk of self-harm.

A key step in the provision of drug services for prisoners is an official recognition that drugs are often available in prison and that some prisoners will engage in high risk behaviour (for example, injecting drug use). The availability of drugs in prison was officially acknowledged in most of the sample countries. The extent of drug use that occurred was variable between prisons within a country. While an emphasis on reducing the supply of drugs entering the prison goes some way to reducing the incidence of drug use in prison, it is also necessary to provide more activities for prisoners in order to reduce the boredom of prison life and to offer a range of drug treatment options.

HIV, hepatitis B and C are major challenges facing prisons in Europe. However, while HIV testing is available in the majority of prison systems, testing for hepatitis is very rarely available to injecting drug users at entry to prison and this

results in a lack of prevention messages and vaccination programmes. As prison administrations receive more prisoners with a history of problematic drug use, the prevalence of hepatitis C and HIV may become much higher. If voluntary testing for HIV and HCV becomes more accessible for prisoners this will also raise the need for more pre- and post-test counselling. The need for pre- and post-test counselling was illustrated by the situation in Hungary where HIV testing, after being compulsory, is now voluntary at entry to prison and where the number of prisoners who want to take the test is gradually falling. Prison systems have a moral responsibility to prevent the spread of infectious diseases among prisoners, to prison staff and to the public and to care for prisoners living with HIV and other infections. The emergence of HIV anti-retroviral treatments and combination therapies have been successful in improving the health of people living with HIV and prisons present an opportunity for prisoners (particularly injecting drug users) to have a (voluntary) HIV test and to access treatment if required.

Testing for HIV in particular is not transparent in all the prison systems of the sample: even where testing is voluntary, not all prisoners are made fully aware of what they are being tested for. This demonstrates very clearly and emphasises the importance and need for good pre-and post-test counselling supported by a programme of staff training. The general feeling amongst staff working in the sample prisons was that there was a need for more staff training in the field of drugs and communicable diseases as this was important in order to meet the needs of an ever-increasing number of drug-dependent prisoners entering the prisons. The training available for staff in the area of communicable diseases was not consistently provided across the sample and no training was available in some of the prison systems.

While most prison administrations are looking at the issue of problematic drug use in prisons seriously, harm reduction is still not receiving serious attention in all of the countries visited because of competing priorities. As prison policy is often implemented differently in different prisons, prevention measures such as condoms, bleach and information provision are sporadic and patchy. Provision of such prevention materials is often dependent on short-term programmes provided by NGOs and international bodies and ceases at the end of the project. However, the development of prevention measures should be seen as an opportunity to meet the health and treatment needs of problematic drug users – a group often difficult to reach in the community that is increasingly represented in prison in all the countries.

Condoms form a crucial component of a harm reduction strategy, even though they will not totally stop the risk of transmission of sexually transmittable infections. They are provided for intimate visits in some countries but for general use only in Estonian and Slovenian prisons. In most of the countries they can be bought in the prison shop. However, in reality prisoners are deterred from buying condoms openly because of the taboo surrounding men having sex with men and because they simply do not have enough money. In order to introduce condoms

into prisons for general use, there is a need first for training to change the attitudes of both staff and prisoners.

A vital component in any harm reduction strategy for problematic drug use is syringe exchange programmes (SEP). However, although the prison services of some of the countries indicated that they would consider the possibility of introducing this strategy in the future, they reported that currently their priority was on supply reduction of drugs rather than on harm reduction. Strategies such as syringe exchange programmes, where they already exist, acknowledge prisoners' rights to treatment whilst ensuring that while they continue to use drugs, they are not spreading infectious diseases. SEPs have been shown to be feasible in terms of their implementation, efficient and effective in that they do not increase injecting drug use and are not misused by prisoners. In conjunction with other measures, they form an important part of reducing the harm caused by problematic drug use; however, as with other measures, to be delivered properly they need to be accepted by prison authorities and given the appropriate resources and management (Stöver & Nelles, 2003).

There is a divergence between what treatments are officially available and what the prisoners, in effect, have access to. Substitution treatment was available in Poland and in Slovenia but not in the other eight sample countries. Detoxification was available in most of the countries either at a prison hospital or through being provided by an external organisation. However, some prisoners have pointed out that they had not received sufficient help during detoxification and in some cases had been provided with no services at all. Whilst the main aim of substitution treatment is abstinence from illegal drug use it is another important strategy for reducing the harm caused by problematic drug use:

many patients are unable to achieve complete abstinence, despite improvements in their health and well being. However, there is clear evidence that methadone maintenance significantly reduces unsafe injection practices of those who are in treatment, and hence the risk of HIV infection. (WHO, 2004)

Provision of harm reduction information to prisoners was reliant in some cases on non-interactive methods, such as written information or a video supplied by the prison department. This also raises the issue as to how well-informed about harm reduction measures are those prisoners who are not drug users. The problem of providing effective harm reduction information is more acute for pre-trial prisoners, because they may only be in prison for short periods, thus making programmes harder to provide, and they may be difficult to access due to restrictions imposed by the court.

The fundamental problem facing attempts to address problematic drug use across the sample prisons was the lack of any formalised prison drug strategy in any of the ten countries. Even in those countries where a more formal approach was taken, it was usually developed from the National Drug Strategy and its main focus was often on supply reduction rather than demand reduction. Most experts and policy makers agree that in order to meet the needs of problematic drug users

‘it must not be either supply reduction or demand reduction but that both strategies must get simultaneously equal attention and funding’ (Goos, 1996). The fact that drug use in prisons occurs and in some of the countries is increasing makes it imperative that prisons provide services that meet the needs of this group of prisoners:

the measures taken must be balanced with the requirements for security and good order [in the prison]. The goals pursued should also be pragmatic, not only with respect to the prison system but also with respect to the prisoners; harm reduction should be the guiding philosophy behind the measures. (Stöver, 2001:93)

The research suggests that the lack of a drug strategy in the prison administration impacts on the development of suitable drug treatments for prisoners. In some of the countries the lack of drug treatment was raised as a problem both by prisoners and by some staff. Amongst the ten countries a range of treatment options were available but were not available in all prisons within a country or in all of the countries. In some of the countries the courts ordered compulsory drug treatment as part of the prisoners’ sentence. Important research is necessary to establish how far there is a difference between the outcomes of voluntary and compulsory drug treatment programmes. The voluntary treatment options for prisoners, available among the sample countries, included drug free zones, open prisons, prison based treatment programmes involving individual and group work and NGO projects and partnership.

The research has shown that negative attitudes towards drug treatment are widespread amongst prisoners within the prisons of central and eastern Europe and that this is a major barrier to change. It is not sufficient just to provide drug treatment programmes because there is a culture amongst the prisoners not to seek help with drug addiction and this also needs to be addressed. Peer education is one way of encouraging more prisoners to attend drug programmes and this was seen to have a positive effect in persuading prisoners to seek help with drug dependency problems. In addition, some staff and prisoners from some sample prisons felt that some prison staff held very negative attitudes towards drug using prisoners. The training provided for staff to improve their expertise on drug use and communicable diseases is crucial to ensure the continuing development of services for drug users in prison and to challenge negative stereotypes of problematic drug users.

A key role has been played by NGOs in providing services and support for prisoners. The NGOs offering drug services that were visited during the course of the research had a range of involvement in all but two of the prison systems. They were actively involved in a range of activities, such as reintegration of prisoners, through care, counselling and support, therapy and rehabilitation, HIV

prevention, provision of harm reduction information, peer programmes and training staff and prisoners. Specialist staff from the NGOs visited raised a number of problems that they encountered in their work with the prison systems. In some prisons NGOs, due to their short history, are still viewed with suspicion. The cooperation that they receive in prisons can be dependent on specific people within each institution. Often the NGOs have to make compromises when they work in prison and to agree to practices that they would not use in the wider community.

In order for partnership between NGOs and prisons to be productive it is important that the NGOs are well organised with professional staff and that there is good collaboration with the national prison service (this could be in the form of a written contract) as well as commitment from management in individual prisons.. NGOs have an important and valuable role to play in the provision of drug services for prisoners and in providing a bridge between the prison and the community. Programmes that are provided by NGOs should be accessible to problematic drug users in all prisons where they are required and should include clear procedures, measurable standards, and monitoring and evaluation of the activities. In order to address the issue of sustainability in short term funded programmes the learning from the NGO programmes operating in particular prisons should be embedded into the prison structure to enable continuing provision for prisoners when the programme ends.

The provision of through care is a developing area in the sample countries and was identified as a problem in all of them. Most of the prisons in the research identified NGOs as having a key role to play in providing through care. In all of the sample prisons some of the representatives of religious groups who were present there offered a degree of support to prisoners after release from prison. In most of the prisons there were also NGOs offering support in specific areas to prisoners at the time of release. But there were not always services available to help prisoners at the time of release in the community. Staff in some prisons felt that the development of the probation service in their communities would eventually help to improve through care for prisoners.

Finally, it is clear from this study that multi-disciplinary working is essential to the success of initiatives across central and eastern European prisons and this appears to have been accepted by many staff. Nevertheless, the research has shown that multi-disciplinary working is not happening in all the sample prisons. Staff shortages and a high prison population are suggested as reasons why multi-disciplinary working, although desirable, was not always possible. Multi-disciplinary working tended to be most effective in prisons where top management took the lead in instigating this way of working.

Suggestions for further consideration

There is, already in existence, a wide range of recommendations for the prison setting provided by international bodies covering prisoners' human rights, health care, harm reduction and drug treatment (Canadian HIV/AIDS Legal Network, 2004⁵¹). It is therefore not considered appropriate to make recommendations that cover the ten countries that participated in the research. Rather, in order to find the best solutions for the particular problems in the sample prisons, it may be helpful for staff to discuss the key issues that have been identified in the report. The following points aim to provide a focus for this discussion. The suggestions are not aimed at specific countries or prisons and are meant to reflect the range of experiences that the countries involved in the research are experiencing and to enable the sharing of best practice.

1. As the number of drug users entering the prison systems increases there will be a need for a range of services and treatment options to meet their needs. At the time of the research not all of the prison administrations had a drug strategy. It is suggested that:
 - the prison administrations need to develop a drug strategy for dissemination to all prisons, focusing on both supply and demand reduction;
 - each prison needs to adapt the national prison administration's drug strategy and develop its own specific drug strategy to meet the particular circumstances in the prison;
 - the particular needs of women and juveniles must be addressed;
 - in prisons where there are both pre-trial and sentenced prisoners, the drug strategy should meet the requirements of both groups.
2. Problematic drug users have different needs and this should be reflected in the treatment and therapy provided. In some countries drug treatment can be ordered by the courts. Compulsory treatment is not considered by many professionals to be effective and therefore a number of voluntary options are also required. It is suggested that:
 - a range of training and treatment opportunities for prisoners with problematic drug use should be developed and be available in prisons with problematic drug users;
 - methods to identify problematic drug users should not discriminate against them and cause them to be reluctant to seek help in addressing their drug use;
 - drug services should be developed that meet the needs of non-native speaking prisoners ;
 - evaluation should be built into the implementation of all new initiatives for drug treatment and services;

51 This document provides a useful discussion of the legal instruments that apply to prisoners' rights and can be found at: <http://aidslaw.ca/bangkok2004/prisonsatellite-background.pdf>. See also The European Prison Rules (Council of Europe Rec.R (87)3) at: [http://www.Coe.int/T/E/Legal-affairs/Legal-cooperation/Prisons_and_alternatives/Legal-instruments/Rec.R \(87\) 3.asp](http://www.Coe.int/T/E/Legal-affairs/Legal-cooperation/Prisons_and_alternatives/Legal-instruments/Rec.R(87)3.asp) and The Dublin Declaration at <http://www.iprt.ie/publication>

- drug using prisoners should be encouraged to seek help with drug use by, for example, the use of peer support;
 - prison based treatment programmes (for example Drug Free Units) should have clear national standards and should where appropriate establish partnerships with drug services in the community (NGOs and community services).
3. At the time of the visit not all the national prison administrations were actively working with NGOs who provide services for drug users. Working in partnership with NGOs offering drug services was seen as important in those countries where there were links with NGOs. It is suggested that:
- continuing effort should be made to establish partnerships with NGOs who offer services for drug users, especially in countries who currently do not have such links;
 - programmes that are provided by NGOs should be accessible to problematic drug users in all prisons where they are required;
 - programmes provided by NGOs should include clear procedures, measurable standards, monitoring and evaluation of the activities;
 - to address the issue of sustainability in short term funded programmes the learning from the NGO programmes operating in particular prisons should be embedded into the prison structure to enable [the] continuing provision for prisoners when the programme ends;
 - in order to ensure effective collaboration between the national prison administration and NGOs providing services there needs to be commitment from individual prison managements as well as from the national prison administration (this could be in the form of a written contract);
 - where possible, occupational activities and training for prisoners should be provided.
4. Not all the national prison administrations considered harm reduction to be a key priority. That risk behaviour is occurring in prisons has been acknowledged and demonstrates the need for a range of harm reduction measures. It is suggested that:
- a harm reduction strategy should be developed to ensure the provision of information and services to meet the needs of prisoners;
 - harm reduction materials should be available for **all** prisoners both sentenced and pre-trial. There should be clear procedures, measurable standards, monitoring and evaluation of the provision;
 - materials should be made available where appropriate to meet the needs of non-national prisoners (to overcome language and cultural barriers);
 - there should be a named person (or group of people) in the prison who has the responsibility of ensuring that **all** prisoners receive this information;
 - the possibility of providing condoms for general use within prisons, and educational programmes to change attitudes towards such initiatives, should be explored;

- courses that address prevention and harm reduction in an interactive way (i.e. courses on the safer use of drugs and on safe sex) should be supported and provided on a regular basis for prisoners and staff;
 - the provision of needle exchange in prisons should be kept under review.
5. At the current time substitution treatment is provided by two of the countries involved in the research. It is suggested that:
 - discussion about whether to offer substitution treatment in prison should continue. It may be helpful to include the NGOs with experience in this area in the discussions;
 - a programme of staff training should be established to ensure the future cooperation of prison staff in such programmes;
 - a national strategy should be prepared for the implementation of the substitution programme, in order to overcome problems with the transfer of prisoners between prisons and from prison to the community;
 - close cooperation and links with community-based services need to be established.
 6. Prisoners often come from vulnerable groups and it is important that prison health care provision is equivalent to that in the wider community. It is suggested that:
 - the practice of leaving security staff to distribute medicines should be re-considered;
 - strategies should be employed to ensure prisoners' confidentiality;
 - health care budgets should be kept under review to meet the needs of the prison population by providing adequate health care services and medicines, as far as possible free of charge;
 - financial investment in basic needs such as food, space, hygiene should be continued;
 - co-operation and the integration of services between Ministries of Health and Justice should be explored;
 - the particular health needs of women and juveniles should be addressed;
 - the same basic methods used for good and effective public health services should be used for good and effective prison health services.
 7. HIV, hepatitis B and C are major challenges facing prisons in Europe. The availability of testing for hepatitis amongst injecting drug users is very rare at entry to prison with the result that there is a lack of prevention messages and vaccination programmes (for hepatitis B). It is suggested that:
 - pre and post-test counselling should be provided in a consistent way in all prisons;
 - HIV testing protocols should be implemented and adhered to in all prisons;
 - staff training programmes should be implemented to provide training in pre and post-test counselling;
 - implementation of strategies that provide prevention messages and vaccination programmes for hepatitis should be considered;
 - treatment and prevention of communicable diseases (HIV, TB, STDs, hepatitis B and C) should be provided.

8. Training for staff in the area of communicable diseases in the sample prisons was not consistently provided. In some prisons staff training regarding communicable diseases and drugs was not provided at all and some staff said that they tended to get information about communicable diseases for themselves. It is suggested that:
 - the precise training needs of the prison staff should be evaluated in terms of the changing nature of the prison population;
 - courses that address prevention and harm reduction should continue to be supported and provided on a regular basis for staff;
 - courses that address drugs issues should be provided in order to decrease negative feelings towards drug users amongst some staff.
9. Bullying and forced sex can be a result of the prisoner hierarchy and in order to reduce the effect of this it is suggested that:
 - there should be a clear anti-bullying strategy in place;
 - a 'whole prison' approach should be developed where all staff and prisoners show a commitment to reduce and prevent bullying and are aware of the prison anti-bullying strategies;
 - measures should be taken to reduce the power of the prisoner hierarchy;
 - specific protection should be provided for vulnerable prisoners, such as those who are HIV-positive.
10. Staff training is important in a number of areas and training was identified as a key issue by participants in the research. It is suggested that:
 - training should be provided that challenges negative attitudes to prisoners who self-harm;
 - there is a need for a holistic approach where all staff and prisoners show a commitment to reduce and prevent self-harm;
 - training should be provided to encourage multi-disciplinary working;
 - induction programmes and mentoring schemes should be provided for new staff, where appropriate.
11. Staff health and welfare are important issues and it is the national prison administration's duty to ensure the wellbeing of staff working in prisons. It is suggested that:
 - there should be a clear policy concerning the health and welfare of prison staff that provides them with appropriate medical and psychological support.

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Appendix

Checklist

General Information

1. What is the current prison population? Including pre-trial detainees.
Is this rising? Why?
2. Overcrowding a problem in pre-trial prisons?
3. Is the number of foreign prisoners rising? Issue with language – translation of materials?
4. How are things generally in the prison service? Budget? New building and repairs, staff vacancies, staff salaries, legislation.
5. Do you have any staff vacancies – nurse, doctors, medical specialists, educators, guards, psychologists, other?
6. What provision is made for staff welfare? (housing, medical care, counselling, other)
7. How is bullying dealt with in the prison? Is there a strategy?
8. Is sex within the prison an acknowledged issue/problem? Are there ‘intimate rooms’ for conjugal visits?
9. What throughcare is available for prisoners and who is responsible for this?

Drug Strategy for Prisons

10. Is there a prison drugs strategy? Is it the same as/co-coordinated with the national drug strategy? Developed in conjunction with the police? Does each prison develop the strategy to suit their prison?
11. Is there considered to be a drug problem in the prisons with:
 - a) Drugs getting into prison
 - b) High number of prisoners with an addiction
 - c) Use of prescribed medicines
 - d) Other
12. Are there now programmes for drug addicts? Set by the court? Voluntary? In all prisons? Where? How many? Available for men, women, YOIs?
13. Have drug free units been established?
14. What NGOs work with the prison re drug users?
15. Alcohol treatment programmes – how many prisons are they available in?

Prison Health Care (in the whole Prison System)

1. Is there a central budget set for health care in prison or does each prison have a separate budget? How is health care organised?
2. Do you have any staff vacancies – nurse, doctors, specialists?
3. Is there a drug strategy? Are you involved with it? Development of it?
4. Do you think there is a rising drug problem in the prison system?
 - a) Drugs getting into prison
 - b) High number of prisoners with an addiction
 - c) Use of prescribed medicines
 - d) Other
5. Do all health care staff have basic substance misuse training?
6. Are there now programmes for drug addicts? Drug free units been established? Methadone provided? Other? Detox? NGOs/police provide this?
7. Alcohol treatment programmes – how many and are they available in all prisons?

Harm Reduction

8. Is there a centrally designed harm reduction strategy for all prisons? What does it consist of? HIV prevention (dealing with blood spills, communicable diseases (TB, hepatitis, etc)? Who delivers the information for harm reduction? Content? Do community groups have a role in delivery? Do all prisoners receive this? Is prevalence of communicable diseases monitored centrally? Are all prisoners tested for HIV, hepatitis?
9. Is prisoner confidentiality ensured? How? Problems?
10. What are your views about the provision of harm reduction materials, such as, condoms, clean needles, drug free wings?
11. Is sex within the prison an acknowledged issue/ problem?
12. Do all health care staff have basic communicable diseases training?
Other prison staff?
13. Is there an assessment tool used with prisoners to identify problem areas (risk of self-harming/suicide etc?)
14. Do you have a suicide and self-harming strategy? Prevalence?

Prisoner Focus Group Sheet

<p>What help is available for those with a drug addiction in the prison? What help did you receive?</p>	<p>Are drugs being used in the prison? What Kinds of drugs?</p>
<p>Are you aware of risk behaviour? Should things like condoms be available?</p>	<p>What two things you would like to change in the prison?</p>

Questions for NGOs working in the community and or in prison

General Questions

1. Please briefly provide an overview of your services' aims, function, size, client base and type of services provided?
2. Is your organisation national? If so where in the country does it exist?
3. What is the philosophy that underpins your practice i.e. Abstinence, harm reduction, other?
4. How are you funded?
5. What are the key problems that you face in implementing your service? (could be community, prison level, mentality, lack of resources, social pressure and stigmatisation)
6. Do you offer throughcare for prisoners?
7. Do you see a role for your organisation in working with the prison service/prisons?
8. What is the feeling about drug users in the local community?
9. Do you work with non-nationals?

NGOs working in/with Prisons

10. Have you found the prison service headquarters (Director general etc) to be supportive and co-operative to your organisation in implementing the services that you provide?
11. What support does your service offer prisoners?
 - Telephone contact
 - Counselling
 - Group work
 - Harm reduction materials
 - Involvement in prisoners sentence planning
 - Written information about your services
 - Throughcare – if yes what?
 - Other?
12. What support do you offer prison staff?
 - Throughcare for prisoners after release
 - Liaising with prisoners' families
 - Provision of courses on drugs
 - Provision of harm reduction materials
 - Other?
13. How long have you/your organisation been coming to the prison?
14. How many prisons do you work with?
15. Do you have good access to prisoners?
16. Do you have good co-operation from prison staff?
 - How could this be improved?
17. What are the key problems that prisoners identify to you?
18. What is the feeling about prisoners in the local community?
19. Do you provide any services/help for foreign prisoners?