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Prison Health Care in the Czech Republic, Hungary and Poland

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Table of Contents

INTRODUCTION.....	5
BACKGROUND TO THE STUDY	5
DESCRIPTION OF THE STUDY	5
COMMON PROBLEMS FACING THE THREE PRISON SYSTEMS	5
OVERCROWDING	5
IMPACT ON HEALTH	7
FOREIGN PRISONERS	7
BUDGET CONSTRAINTS	7
DRUGS.....	8
ALCOHOL.....	10
SEX IN PRISON	11
STRUCTURE OF THE PRISON HEALTH CARE SYSTEMS	12
CONFIDENTIALITY	15
STAFFING	15
EQUIVALENCE OF CARE.....	16
TREATMENT PROGRAMMES	17
HEALTH PROMOTION	20
PRISON PRACTICES AFFECTING THE HEALTH OF PRISONERS.....	22
CLEANLINESS AND HYGIENE.....	22
FOOD IN PRISON.....	22
ACTIVITIES AND WORK	23
KEY ISSUES IN HEALTH PROVISION	24
HIV	24
TUBERCULOSIS (TB).....	26
HEPATITIS	27
SYPHILIS.....	27
TERMINALLY ILL PRISONERS.....	27
DENTIST AND OPTICIANS	28
THE ROLE OF THE PRISON DOCTOR IN PUNISHMENTS	28
CONCLUSIONS	28
REFERENCES.....	31

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Introduction

Background to the study

This study of health care in Central European penal systems was commissioned by HEUNI and took place during January and February, 2001. The three countries included in the research were the Czech Republic, Hungary and Poland. These countries were selected to complement the work already done by Roy Walmsley (1996) and his current follow-up study of the prison systems as a whole in Central and Eastern European countries. The link with Roy Walmsley's research was important as a means of securing access to appropriate key personnel in each of the countries and as a means of securing general information about the prison systems.

This study also complements the work already carried out in Italy and England and Wales about the structure and key issues facing the two prison systems in the areas of health policy and more specifically on HIV and drugs policy (MacDonald, 1999).

Description of the study

The purpose of the visits to the Czech Republic, Hungary and Poland was to prepare a report that provides descriptive data about the current health policies in prisons in the countries visited. Interviews were to be carried out with key officials in each of the countries to discover the extent to which international standards are currently adhered to in the implementation of health policy; the reasons for any lack of adherence; the concerns expressed, and the state of progress.

It is the intention to return to each of these countries to undertake a more in-depth follow-up study in the area of implementation of health policy in the form of audits in a sample of prisons, which will also include interviews with prisoners.

Although this report is primarily concerned with the provision of health care services in each of the three countries' prison services it is also recognised that there are other factors that make a significant contribution to the health of prisoners. Therefore, a variety of issues (overcrowding, budget constraints, drugs and sex in prison and so on) have been included in the report in so far as they impact on prisoner health.

Three days were spent in each country. Interviews were carried out with a range of key officials in the prison service administration. At least one prison was visited in each country and further interviews were undertaken with the prison governor and medical staff working in the prison hospital/department.

Common problems facing the three prison systems

Overcrowding

At the time of the visits all three countries were experiencing overcrowding in their prison systems. This was considered to be a major problem in the delivery of health and treatment programmes for prisoners. In Poland, overcrowding in the prison system has resulted in the adaptation of some rooms used for cultural events to

increase the amount of cell space for prisoners. The 130% overcrowding of the Polish prison system means that there are some problems with the care for prisoners where case managers¹ have to care for approximately 130 remand prisoners now instead of their usual case load of 60 prisoners. Overcrowding is particularly a problem in big cities and in pre-trial and closed prisons in Poland. The feeling in the Polish Prison Service is that the prison population will continue to rise. This increasing prison population is leading to more repressive regimes for prisoners. In a time of overcrowding, it is much harder to place women prisoners, near their homes, due to the small number of women's prisons. As the prison governor of Bialoleka Prison in Warsaw said, they have "had to limit some prisoner rights and although the current atmosphere is good, overcrowding is a time bomb waiting to go off".

In Hungary, overcrowding in pre-trial prisons was considered to be a major problem for the prison service. There is currently 160% overcrowding in sentenced prisons and 250% overcrowding in the remand houses. As of 30 September, 2000 there were 15,778 prisoners: 14,728 were male with 737 (5%) being foreigners; 1,050 female prisoners and 50 (5%) being foreigners.

In Hungary there is a new prison building programme in progress. Two years budget has been agreed to allow for this building programme and

¹ Case managers are key workers in the Polish prison system. Case managers are normally graduates. They work closely with the security guard on the prison section. The role of the case manager is to look after the general welfare of prisoners and involves prisoners' personal problems, problems with their sentence and the organisation of cultural events.

modernisation of old buildings to improve the conditions for prisoners.

Increasing the number of places for prisoners does not solve the problem of a growing prison population. The Hungarian Prison Service would like to decrease overcrowding, provide more areas for cultural activities for prisoners and to be able to provide differentiated regimes for prisoners. The rate of increase in the prison population has gone down this year by 2% and by 7% compared to two years ago. Some reasons given for this were:

- that home detention had been introduced;
- that part of the sentence could be served at home following the Scandinavian example;
- that there had been a decrease in the number of people sent to prison and that public opinion in Hungary endorsed this.

The situation in prisons is considered to have improved in the Czech Republic with the Deputy General's introduction of new management and new approaches to prisoner care that are nearer to European standards. There have been some disturbances in Czech prisons, which were a result of the current overcrowding although the prison population has gone down between October and December, 2000 with a decrease in the number of both pre-trial and sentenced prisoners across the Czech Republic. Consequently, the prisons are not so crowded as they were a year ago. The Court proceedings and interrogation process have been speeded up and there is more use of alternative punishments. This has resulted in a reduction in the length of time a prisoner spends in pre-

trial detention. In May/June, 2000 a prisoner spent approximately 11–12 months in pre-trial detention whereas the current situation is approximately 5–6 months.

Impact on health

Overcrowding impacts on prisoner health in a variety of ways. When the number of prisoners per cell is increased this places a strain on hygiene, available washing facilities and personal space. In all the three countries the space per prisoner was often less than the stated minimum in their legislation. In the Hungarian prison system, most cells are for two prisoners but in reality there are four prisoners per cell. Prisoners only have one hour out of cell. It is considered to be an achievement that the Prison Service can ensure this one hour. There is an awareness that there needs to be more prison programmes, for example, simple unskilled work, which occupies prisoners. This is considered to be important because it allows prisoners to earn some money, provides an occupation to kill time, provides a new way of living and learning how to work and reduces the amount of time in cells.

In the Czech Republic, time out of cells for pre-trial prisoners is mostly one hour per day but there is a unit for 300 pre-trial prisoners with a changed regime where cells are open for 12 hours, which allows prisoners to walk about the wing. The unit is not full, as some people are not suitable for it because of concern about collusion between prisoners in the period before their court hearing.

There are a small number of single cells but usually there are three to five prisoners per cell in the Polish prison

system. In the diagnostic section² of prisons, the hours out of cells are three or four per day.

Foreign prisoners

In Hungary the number of foreign prisoners has been rising since 1993 with 807 in (2001) spread across sentenced and pre-sentenced prisons. In Poland there are 944 foreign prisoners in prison. The split of Czechoslovakia gave rise to a high number of foreign prisoners in the Czech Republic (especially Slovak gypsies). Currently, there are between 3000 to 4000 foreign prisoners.

In the three countries foreign prisoners are offered the same treatment as national prisoners but this group do raise some problems, for example, with language and the prison budgets.

Budget constraints

In all three countries improvements to regimes for prisoners were constrained by budgetary concerns. In Poland, the current government are perceived as not understanding the problems faced by the prison system and prisons are low on the government's list of priorities. This was considered to be a short-sighted view because if Poland wants to be integrated into Europe then society should not ignore the need to ensure appropriate prison standards and the human rights of prisoners. It was felt that money was found by the politicians as a response to crises in the prison system and that as

² The diagnostic Wings are for newly sentenced prisoners where they undergo psychological tests prior to being moved to other areas of the prison. The staff on the diagnostic section consists of psychologists, a case manager and security staff. There is teamwork between case manager, psychologist, psychiatrist and security - they all work together.

long as the Prison Service maintains a good atmosphere in prisons the politicians ignore the situation.

The feeling in the Czech Republic echoed the view in Poland. The key problem was perceived as the lack of budget for prisons and a lack of interest from the state towards prisons. The Governor of Pankrac prison in Prague felt that problems with the budget have caused staff shortages (the number of employees is fixed by the government) as Parliament did not increase staffing or the budget. There is a shortage of money for salaries. Staff in the prison did not get their overtime payment and they have been promised that they will get it this month (February, 2001). The governor considers that staff morale was previously good but that some individuals are dissatisfied and if non payment of overtime happens again it will not be possible to guarantee staff attitudes.

Drugs

Drugs and drug addicts in prison were identified as a problem in each of the countries. However, the extent of the problem differed between the countries.

Hungary in the past has tended to be a transit country for drugs but now there is a growing problem with drug use in the wider society, which is gradually being reflected in the prison population. Parliament is currently designing a national drug strategy and the prison drug strategy will be developed from this. The Prison Service response to drugs currently involves staff education, attempting to minimise the amount of drugs that get into prisons and the introduction of drug free units. At the moment, there is not considered to be a drug problem in prison but they are

trying to solve any potential problems. The amount of drug addiction is increasing and they are concerned that it may increase in prison. The new criminal code allows for more severe sentencing for drug related crime.

The Hungarian statistics show a picture of minimal drug use in prison. There were only three cases of drugs found last year during searches by staff using drug dogs in some instances. There is rare use of drugs and it is felt to be under control so far but the Prison Service is aware that this is a growing problem.

There is no use of methadone for detoxification in Hungarian prisons. Instead there is some possibility of psychiatric treatment. However, as most people will have spent a considerable time in police custody most detoxification will happen at that point.

In some circumstances the court may decide that a drug addict can be permitted to go for alternative treatment and then return to prison. Some prisoners have been sentenced to alternative treatment but also have to be in prison due to the serious nature of their crime and these prisoners have individual treatment involving drug therapy in prison. In the new law, the health care department would like to introduce a drug-free unit for prevention purposes but this is problematic as all of the prison should be drug free! Attendance at psychological or psychiatric groups is voluntary for drug addicts.

Cleansing materials (for cleaning needles and syringes) are not available in Hungarian prisons. However, there is harm-reduction literature that has been translated for use with non-national

prisoners. Drugs involve a special sentence and drugs in prison are a hidden problem. Testing for drugs will be introduced soon but the tests are very expensive and there is not a legal regulation to force a prisoner to take the test.

There is a national drugs strategy in the Czech Republic, which follows through into the prison drug strategy. There is a growing drug problem in the community with cocaine being popular and an increasing use of heroin. Drugs are also a developing problem in prison where drugs such as pervatin³, cannabis, pills and, exceptionally, injecting drug use occurs. Drugs are seen as a problem but still not yet as a major problem in prison. The main problem regarding drugs is the use of pills (medicines) distributed by the medical department. The medical care in prison is at a high level but they use many medicines with prisoners and so pills are easily accessible. Prisoners should swallow the pills when they are given them but this does not always happen. There is also some abuse of the use of painkillers that it is legal for prisoners to keep. The prison staff monitor the consumption of certain legal medicines in the prison to ensure they are not being used to produce illegal drugs.

The Czech Republic drug strategy covers a three-year period. Last year, the programme for 1997–2000 was completed. The programme has been separated into three parts:

- reduction of supply into prison;
- primary prevention and education in prison;
- treatment for hard drug users.

³ Pervatin is an amphetamine drug made in the Czech Republic.

During the period 2001–2004, the emphasis will be on drug-free units. The intention is to use the Austrian model that started in Austria in 1995 and was based on programmes that existed in Holland and England. It is a mixture of different strategies to meet the Central European situation.

Drugs are not routinely tested for in prisons in the Czech Republic. Registered drug addicts are asked at the entry check up if they are dependent on alcohol or drugs. At the time of the entry check-up, urine tests monitor drugs like amphetamines, opium, benzodiazapines, barbiturates, cocaine and cannabis. This has been done for the last four or five years and, so far, about 20% of the check-ups were positive. During 2000, 5763 people were tested and 1269 were positive on arrival at prison

Despite the apparently high rate of drug use at entry, a recent research study has questioned the level of drug use in the prison. The study took place in two randomly selected Czech prisons for sentenced prisoners. It found that, during 1999, of 730 prisoners tested in the first prison there were 12 positive (1.69%) drug tests. In the other prison, of 470 prisoners tested 35 positive results were recorded and none of these were using prescribed medicines. Detection of hard drugs is exceptional and tends to be restricted to isolated individuals. Only eight of the positive tests at the second prison in the research study, were cocaine (23%), 12 of the 35 positive tests were using Parvatin (35%). When needles are found which are not used for official treatment, they are destroyed.

There is special treatment for drug addicts in three prisons in the Czech Republic. In one prison, there is a special

unit that can accommodate 160 prisoners who are drug addicted. Currently however, it is only operating for 100 people.

There is now a wider use of drugs in the community in Poland, including some heroin-injecting drug users. 70% of these drug users are also HIV-positive. There is relatively little injecting drug use in the wider community, rather there is more use of drug cocktails and alcohol. One of the most popular drugs is UFO⁴ a drug particular to Poland. Drugs are seen as a growing problem in Polish society.

In 1994, after a trip to then English Prison Service, the Polish prison administration were advised that they would eventually be likely to have a drugs problem in Poland. The economic changes in Poland, trends and fashions have given rise to a market for amphetamines and alcohol. Now there is also a problem as a wide selection of drugs are being smuggled into the prisons including cocaine, cannabis, and heroin. Independent research is being done about the extent of drug use within prison with a grant from the Ministry of Health. There will be a report in 2002. All admissions to the prison are asked if they are using drugs (using an anonymous questionnaire) plus people in the special therapeutic wards will receive a questionnaire. Information from security guards about the drugs found will also be recorded. There will also be anonymous urine checks to find out what illegal drug use is happening in the prison. There will be training for prison officers on how to detect drugs and drug dogs are being used to search cells. The newest development is consideration of using tests for detecting drugs and training their own drug dogs

in the prison administration. It seems that the drugs in prison are mostly eaten not injected, as syringes have not been found.

Methadone substitution is going to be introduced in two Polish prisons. The local Health Authority will support a project in the two prisons. Methadone will come from the National Centre for Drug Addiction. This project will start later in 2001. There are about 1000 addicts in prison.

Alcohol

In Poland alcohol is seen as a more serious problem than drugs. There are treatment centres available for alcoholism in the community. There are 19 alcoholic sections in the Polish prison system, which use the same philosophy as the Atlantis project in Mokotow Prison. The Atlantis project was visited. Prisoners on this project have to attend the project, as part of their sentence. They undergo both individual and group therapy and live on the unit with five or three to a cell. They wear their own clothes and have to eat together. They are out of the cell from 6 a.m. until 6 p.m. There are 49 prisoners on the programme and it lasts for three months. There is education available and a printing shop. The programme was evaluated in 1993 and it was found that 20% do not drink after one year.

Alcohol is not considered to be a serious problem in Czech Republic prisons. The Prison Service is opening a unit for alcoholics for 30 people next year (2002). Before 1990 there were many units for alcoholics but they were closed as it was thought that capitalism would solve all problems and alcoholism would reduce. There is now a need for their reintroduction.

Compared to Poland, the Czech Republic does not have a big problem with alcohol. The courts do not order many people to have preventative treatment for alcohol (about 20–30 per year). Prisoners at entry to the prison are asked if they are alcoholics and if necessary medicines for alcoholism are used while in prison, where possible.

In Hungary there are some programmes available for prisoners who have a problem with alcohol.

Sex in prison

In the Hungarian Prison Service sex between men is not considered to be a problem as the perception is that it rarely occurs. However, there is considered to be a higher incidence of sexual relations between female prisoners. If homosexual sex is consensual and discreet then there is a lenient attitude.

There are no conjugal rooms available for visits to Hungarian prisoners at the moment. The prison service wants to introduce 'intimate rooms' for conjugal visits or for whole family visits. This would be very useful especially now as short-term leave from the prison has been disallowed. It should be possible to implement these rooms but the prison administration are waiting for the legislation to come from the Ministry of Justice. The legislation is currently in the process of being developed and may start this year (2001) and the main problem will be to find the necessary space in the prison to provide conjugal rooms. Dr. Laszlo Huszar, Director of Budapest Central Prison reinforced the view that sex was not considered to occur in prison.

Condoms are not available in Hungarian prisons. There were plans to install

condom machines but there was not considered to be a need for them. Prisoners can ask the doctor or health-care staff for condoms. Juveniles get condoms prior to release via a project not funded by the prison service.

Sex in Czech prisons is a hidden problem that is difficult to investigate. Exceptionally, there are incidences of violent sex. Sex in prison is against the rules. Sex is not tolerated if it is abusive but if it is consensual it is difficult to do anything about it. In prisons there is a monthly committee (psychologist, head of the unit, social worker, inspector of prisons) that identifies vulnerable prisoners, who may be violent or who may be at risk from sexual violence. Sex amongst women prisoners is more tolerated and there are only about 200 women prisoners. The hidden nature of sex between men in prison is reflected in the wider society in the Czech Republic as was demonstrated by the rejection of the proposal to legalise homosexuality.

In prisons in the Czech Republic it is possible for prisoners to buy condoms from the prison canteen but nobody buys them.

There are some signs of sex occurring in Czech Republic prisons. Medical examination sometimes reveals signs of violent penetration or the spread of a disease, such as hepatitis C, is indicative of sexual activity. People do not like to speak about sex in prison. It is rare that a prisoner will complain about sexual violence, due to shame. Usually the authorities find out indirectly. Overcrowding makes the incidence of sex worse.

Gay male prisoners in the Czech Republic are put into special areas, usually single cells, for their protection.

Aggressive sexual behaviour amongst prisoners is recorded by prison staff. At entry to the prison, prisoners are told to inform security if they see any odd behaviour of a sexual nature.

Condoms are available for Polish prisoners when they go on home leave from the prison. Condoms can be obtained from the medical staff and others but no one asks for them in the prison. Condoms are supplied by the Health Ministry. Some staff feel that providing condoms in prisons raises ethical issues as Poland is a Catholic country.

Structure of the prison health care systems

The Hungarian Prison Medical Service can provide nearly all the inpatient and outpatient treatment that is required. In the thirty one prisons, there are basic treatment sections with a full-time doctor⁵. There may be more than four full time doctors in the bigger prisons and many nurses. In remand prisons, where there are between 100–200 prisoners, part-time doctors are used and 2–5 nurses. These doctors may have retired and are returning to work for the Prison Service on a part-time basis. Health care for prisoners is financed in two ways: from the central budget and from public health insurance.

⁵ If there are more than 500 sentenced prisoners there must be one full time doctor provided.

The central budget for health in Hungary is based on the number of prisoners and most of the budget is allocated to the central prison hospital. The Department of Finance defines the amount of money each prison receives. The same process is used for medicines and medical instruments. Public health insurance is paid through work but prisoners are considered in the same way as students. There is some controversy because non-national prisoners get free treatment while in prison but after they are released into the community they have to pay for any continuing treatment.

In the Czech Republic, prison health care operates on the same principles as the national health care services. Czech citizens are covered by health insurance legislation. If a prisoner is not employed then 60% is paid by the state (up to 20 euros) per month. Every new prisoner has a full medical check up at the time of admission to the prison. This entry check up is the same as in public health regarding physical health. One difference is that an X-ray of the lungs (for TB) and in the case of foreigners a skin test for TB is done as well.

The Czech Prison Health Care Service is more integrated into the National Health Service than it was seven years ago. This has been a deliberate policy and it was emphasised that the controls for public health in the community also control prison health services. The areas covered by these controls are accommodation cleanliness, nutrition and epidemiology. Prison health care is considered to be comparable with the Czech Republic National Health Service. It is sometimes better as it can be quicker to get appointments and care in prison than it is in the community. The availability of

medicines is good in the prisons and the doctor decides which medicines are prescribed and there is the same access as there would be in the community. In the community medicines are divided into three groups and certain medicines have to be paid for. As in the community, those prisoners who can afford to pay have to pay for some medicines. However, most prisoners cannot pay, as they have no money, so they get all their medicines free. The prison medical service makes no profit and if they need to they will prescribe and provide expensive drugs. Foreign prisoners receive the same medical care as Czech nationals. However, as in Hungary, when foreign prisoners leave prison they have to start paying for any medicines.

In the Czech Republic each prison has its own medical centre with at least one full-time doctor. There is no formal rule but there is an unwritten rule that there should be one doctor and three nurses per 500 prisoners in pre-trial prisons. However, normally it is more. When there is an emergency and there is no physician the prisoner is escorted to the nearest emergency hospital. Every prison has a dentist who is either a full-time prison dentist (there are 10 of these) or who is contracted by the prison service. The health-care staff who are contracted are psychiatrists, ear, nose and throat specialists and opticians. Every prison usually has a consulting room for external doctors. Each prison has a budget to pay for contracted staff. There are only four psychiatrists employed by the Czech Republic Prison Service.

New admissions to Czech prisons go to one of 22 prisons where there is a special check up for new prisoners. A blood test is offered to all prisoners. It is possible to

refuse but prisoners are isolated until they do take the test. In reality, most prisoners take the test. An x-ray of the lungs is mandatory every year and before release from the prison if the prisoner is in the prison for longer than three months. From these measures, the prison medical staff are able to detect TB effectively. HIV and TB are not financially covered by health insurance so this comes out of the prison health care budget.

New legislation, in the Czech Republic, that covers the community and prison, stipulates that there has to be a mandatory blood test before an operation.

In Hungary, a doctor is available each day to see prisoners. In some institutions, there may not be a doctor's surgery every day but if a doctor is needed the prisoner can go to another prison or the emergency services will be used.

If it is an emergency a prisoner will see a doctor at once. The prisoner does not have to say why he or she wants to see a doctor. The evaluation of the urgency of the prisoner's request is evaluated by the nurse who is in the prison until 7pm in remand houses and in sentenced prisons there is 24-hour cover. If there is not a nurse in the remand house, the prisoner asks an officer who will then call an ambulance. What constitutes an emergency is defined by law set down by the Ministry of Health Care.

In the central prison hospital in Budapest there are specialists and medical experts. There are 297 beds for in-patients and facilities for out patients. A wide range of specialisms are covered such as, pulmonary, gynaecology, internists, x-ray, intensive care, ear, nose and throat,

dermatology and dentistry. Prisoners can go to outside hospitals in the community if another specialism is required. There is a psychiatric clinic (within the grounds of the central prison) which provides 311 beds. Neurological psychiatry is provided. There is an after care section with 80 beds.

There are three prison hospitals in the Czech prison system. In Prague the hospital is 100 years old and can hold 139 patients, 60 for internal problems and 79 surgical beds. The optimal occupancy is 89. Specialist surgeons come from outside but the nurses and equipment are provided in the hospital. The hospital can also provide x-ray and laboratory services and also has the facilities for out-patients. At the time the hospital was visited it was 80% full, in order to meet the demands of separation of pre-trial prisoners, male and female and the four security categories. There were about 10% female patients and a few juveniles in the hospital. Although most prisoners are treated in the prison hospital, some prisoners are taken to public hospitals but this poses security risks. Last year there were 800 escorts from the prison hospital for check ups, examinations and some operations. The most frequent illnesses treated in the hospital are cardiology and asthma.

The head of this hospital identified dealing with foreigners as a serious problem as they have no health insurance. Some of the costs for their treatment comes out of the prison budget. Therefore, if a prisoner comes to the hospital in Pankrac from another prison the cost for treatment comes out of the Pankrac prison budget. The hospital budget is part of the overall prison budget. The chief doctor liaises with the

deputy governor and they meet every two weeks.

The hospital director has all the medicines that he requires. There are staff shortages in the hospital where there are two nurses, one physician and one medical assistant short.

The prison hospital in Brno was opened in 1997 and is very modern and well equipped and there have been some complaints that the hospital is of a higher standard than those in the community. It has 170 beds. It is not fully used as there are only two psychiatrists employed at the moment. It has an internal department, intensive care, remedial and resuscitation and 28 beds for infectious diseases.

The third hospital is for dealing with TB only. It has 65 beds. Some patients have lung tumours and after diagnosis, prisoners with this are released. Those seriously ill (terminal) are released but the decision is made by the court and in some cases prisoners may die in prison while awaiting the decision.

In Poland, as prisoners are not required to pay medical insurance, medical care in prison is financed from the state budget. The budget for the prison service is worse this year than last year and health care was considered to be the lowest budgetary priority. The head of prisoner health care considers there to be good co-operation between prison health and public health services. The prison health service employs a range of specialists and consultants and has hospital facilities. However, the prison service is not able to cover all branches of medicine nor able to provide 24-hour care for prisoners in all the prisons in Poland. Urgent

consultations, surgical interventions and specialised medical procedures are provided by the public health service and paid for from the prison health-care budget.

There is an out-patients' health centre in all Polish prisons and in some prisons there are some hospital beds. Each section has a doctor and several nurses. They also use outside consultants. Most prisons have X-ray facilities.

There are two large women's prisons in Poland with maternity facilities but there have not been many deliveries this year (2001). The mother-and-baby houses are good. The child can stay in prison with the mother up to three years of age.

There are 14 prison hospitals in the Polish Prison System with 41 special wards. In the hospitals there is physiotherapy and rehabilitation available for disabled people. There are two wards for rehabilitation (one operating and one will be later). The Mokotow prison hospital was visited. It has 155 beds, facilities for rehabilitation and X-ray and is primarily for remand prisoners. I was shown the showers that were very clean and modern and gave prisoners privacy.

It is argued that throughcare in Poland is good because in the Polish prison system the therapeutic staff are obliged to help prisoners to continue their treatment after they are released. In Hungary, it is the doctor's role to keep in touch with the community and a prisoner's notes go both ways.

Confidentiality

In Hungary the general rules in the community, which govern medical confidentiality, have been adopted for the

Prison Medical Service. A prisoner's record is only available to medical staff with two exceptions, the prison governor or the information officer, but it is kept secret. Prisoners who are HIV-positive do not have this marked on their medical file. The result is kept in a sealed envelope that is only opened by the doctor.

There is not a problem with confidentiality between the medical staff and the guards in the prison hospital in Prague. The same guards work in the hospital all the time. When a case is taken to court, for example, if a patient has a terminal illness, the papers are not specific, about the illness. Prisoner's lawyers can only have access to medical records if the prisoner gives consent. The medical staff wanted medical examinations to be done without guards being present. No guards are present during examinations now and this is considered to be an improvement.

Staffing

In Poland the salaries for nurses are higher in the prison than in the community. The same was true for many years for doctors but this is changing as doctors are earning more, since 1999, working in the community. The future may be problematic when trying to recruit doctors. One strategy is trying to train prison doctors as general practitioners (GPs) as it is not easy to get this specialist training (outside). It is a new idea in Poland to have GPs rather than specialists. The Polish Prison Service is taking a long-term view of recruitment.

The Czech Republic also has concerns about the future recruitment of doctors to the Prison Service. At the moment they are experiencing staff shortages. For

example, the Prison Service employs 134 full-time doctors and there should be 143. Currently, approximately 45% of the prison physicians have retired and returned to work for the prison service. Plus working for the prison service is not an attractive career for young doctors. This is despite the opportunity for updating skills, which is very good for doctors as there are many courses during the year where they can meet with colleagues in the health service. Prison doctors have the same status as doctors working in the community. However, there is perceived to be no advantages to work in the prison service and sometimes the behaviour of the patients is difficult. It is also considered to be important that prison doctors have a certain level of experience before being able to work in prisons. Many doctors in the Prison Service are reaching retirement age or are retired and replacing them will be difficult because of salaries. A health insurance agency doctor can command a substantially higher salary than a doctor working for the prison service.

Nurses in Czech prisons are required to have had three years' experience of practice prior to being employed by the Prison Service. However, there are no vacancies for nurses as the salary in the Prison Service is twice as much as that in the community.

In Hungary, there are also staff shortages. The Prison Service employs 95 full-time doctors and there should be 105 and 387 nurses are employed and there should be 410. Health-care staff can receive more money if they are classified as uniformed staff, that is, part of the military. The Prison Service tries to have as many doctors as possible classified as military

staff as a means of keeping the doctors in the prison service.

Equivalence of care

According to the Council of Europe recommendation R (98) concerning the ethical and organisational aspects of health care in prison:

Health policy in prison should be integrated into, and compatible with, national health policy. A prison health care service should be able to provide medical, psychiatric and dental treatment and to implement programmes of hygiene and preventive medicine in conditions comparable to those enjoyed by the general public. (Appendix to Recommendation No. R (98) 7:b)

All three of the countries appear to be meeting this recommendation as far as is possible given the staff shortages previously mentioned. In Poland, they want to get prisoners onto the national health insurance system as in the community to make access to outside facilities easier. In Poland, prisoners get all the specialised care available in the community. The cost per prisoner per day is higher than allowed for the ill in hospitals in the community. The feeling is that prisoner health care is better than staff health care.

In the Czech Republic, the professional control of doctors is regulated both by the health department in the Prison Service and by the Public Health Medical Service. Prisoners are dealt with in the same way

as in the community and have access to the same services. It was argued that health care was better in the prison because there are more facilities and medicines are free. For example, false teeth are expensive but if a prisoner has lost 50% ability to bite then they will get free false teeth in prison.

The professional skills of prison doctors are maintained and updated in the Czech Republic by 'professional' days for doctors and experts when they can work in the community health institutions. The updating is regulated by the Ministry of Health.

In Poland, they have conferences on particular subjects at which a variety of health care staff share the good practices of the different prisons and also share expertise with the community. This works both ways, for example, how to treat people who have swallowed things, which happens a lot in prison, is useful for doctors working in the community where it occurs less frequently.

Treatment programmes

A wide range of treatment programmes have been introduced across the three prison systems. Many prisoners have unhealthy lifestyles outside prison: they are more likely than the general population to smoke, drink, and to take drugs. Prisoners are more likely to have suffered mental illness.

In Hungary, there are programmes for psychopathology, alcohol abusers and information about HIV is delivered in small groups to prisoners. There is also a special project for job finding after release from prison. There is a mental health course. There are problems with suicide

and ideas about prevention are being discussed during this year (2001). The number of suicides has remained constant over the last two years with nine suicides in 1999 and 8 in 2000. The next step that the Hungarian prison administration wishes to develop is to provide programmes for sex offenders and for drug addicts. There are already some small programmes in these areas but they want to expand them.

In the Czech Republic, for standard treatment programmes there should be two pedagogues⁶, one social worker, one psychologist and eight educators⁷ who make up a multi-disciplinary team. There should be two teams in each prison for every 160 prisoners. In the case of specialised treatment for young offenders, there should be one educator for every 10 prisoners, one pedagogue for 20, one psychologist and one social worker for every 40 prisoners. They are also trying to introduce an instructor to provide physical education and vocational training for these groups.

The teams work in a multi-disciplinary way and they have regular meetings. The prison governor is not practically involved in the meetings but he or she has to approve the programmes. In reality, the methodology for the programmes comes from the prison administration and the prisons then prepare their own programmes using the framework. The programmes are then approved and controlled centrally. The

⁶ Pedagogues are teachers who work with prisoners in a range of activities. They have similar qualifications to the educators.

⁷ Educators have responsibility for between 40-60 prisoners who they are expected to get to know well. The educator deals with welfare issues and to respond to prisoners' problems. They need to have at least secondary education and more usually a university degree.

teams are required to meet once per month, but actually meet more frequently, and they have to keep written records. However, this multi-disciplinary way of working is still being developed. The teams also have an influence on policy and changes have been made to health policies. There will be training to work in teams starting in 2001.

In prisons in the Czech Republic there is a special unit available for those with mental health problems, for example, for psychopaths, psychiatric patients and so on. In 2000 they had nine suicides in the prison system.

The Czech Republic prison doctors try not to use methadone in detoxification treatment of drug addicts. However, a prisoner can continue to use methadone if they were on it in the community. During detoxification, the prisoner is left in the public hospital for three weeks, where they will receive benzodiazepines. Prisoners who say that they are drug users are asked to go to the drug unit where they are treated by psychologists, psychiatrists, social workers and nurses. Being on the unit involves mandatory attendance at group work and individual treatment. The quality of the treatment differs but it is good in Pancrac prison. Currently, drug addicts do not have to accept treatment and this is perceived as a problem.

The Czech Prison Service is trying to introduce preventative health care. For example, a special department for prisoners who have committed sexual crimes, used drugs or alcohol and psychiatric treatment is being introduced. The court orders this preventative treatment but it is to start after release from prison. However, the prison service

is starting some treatment before release. The prevention is mostly for psychopaths. Preventative measures (from the Czech Penal Court) include treatment and prevention. This treatment has to be decided by the court, for example, repeated rapists or paedophiles can be sentenced to prison and preventative treatment after the sentence is served. However, the prison administration decided the time to do this prevention is while the prisoner is in the prison as they need to undergo treatment to change behaviour while in prison. There is currently not as much preventative treatment as the prison administration would like but they are trying to establish as many departments as possible for such treatment. In 2001, they want to open a preventative medical department for psychotics who are not responsible for crimes and who cannot be sentenced to prison and a department to treat people who are at risk of suicide.

The strategies for treatment in Polish prisons reflect those in the community on the prevention of drug and alcohol addiction. The law has made it necessary to make available some of these drugs and alcohol programmes in prison. For example, there is co-operation with psychologists trained by public institutions in some prisons as they cannot afford full time specialists and have employed part time people who are also working in the community and who are not prison military staff. The treatment that is offered to prisoners is dependant on their classification by the courts. This includes prisoners who are mentally disturbed, addicts to mind-altering substances and the physically disabled. If assigned to the therapeutic system the prisoner gets some education and then goes onto a waiting list for

treatment. The prisoner will also have access to, for example, Alcoholics Anonymous meetings while waiting to get onto a programme. Young offenders have no choice they have to serve their sentence via a programme. Drug addicts or mentally ill young offenders are automatically assigned to the therapeutic system. The programme is organised by consent and the prisoner takes some responsibility regarding education work and their family. Every six months sentenced young offenders on a programme are assessed by their case manager and the penitentiary commission.

There is specialist treatment for Polish prisoners with a mental illness and they are treated well. Originally, alcoholics and drug addicts were placed in the wings for mentally disturbed prisoners. Now they are introducing new wings. There are 22 wings for the mentally disturbed (1400 prisoners), 11 wings for alcoholics (400 prisoners) and 10 wings for drug addicts (300 prisoners) in Polish prisons.

It is usually psychiatrists or psychologists who are head of these specialist wings. The staff are organised into therapeutic teams consisting of a psychologist, doctor, activity therapist, psychiatrist and case managers. Prisoners are admitted onto the wings based on regulations in the Polish Criminal Executive Code and the prison rules, as approved by the courts. This treatment can be included in the sentence — the court can decide that a person should be placed on a specialist wing. The decision of the court is based on the evidence from forensic experts. The treatment can be individual and group psychotherapy, work and cultural activities as therapy and there are also

links and co-operation with the families of the prisoner. Each prisoner is assigned an individual treatment programme designed by the treatment team. Pharmacological treatment is only used as an addition. There are alcohol and drug-treatment programmes lasting three-to-six months. Those within the system are of the view that there are not enough sections for alcoholics and designing and producing new wings for alcoholics is seen as a difficult task.

The treatment available has been diversified over the years. The treatment methods used in prison have been damaged as the chance for prisoners to work has declined. In the last few months, the prison population has grown so that now each psychologist has an increased caseload. If the prison population continues to grow there will be less and less space in which to offer therapy.

There are 6 wings for psychiatric disorders and 22 wings for therapeutic treatment. There is still a need for more hospital beds as it is difficult to send prisoners outside for treatment as prisoners do not have health insurance and there is then the problem of who is going to pay (although the Polish Ministry of Health do pay for some treatment) There are 20 psychiatric problems' therapeutic wards with a different way of working with individual therapy programmes. Each ward has a psychologist, nurse, educator and guard. It is important that these wards exist as it gives a chance to access professional help, the living conditions are better and there is more freedom than on the other wings. It also teaches prisoners how to survive in the community after being locked up in a cell for years.

There were 44 suicides in Polish prisons during 2000. Cutting is also a frequent problem in prison, mostly done by men, it is unusual for women to do this. The tendency of swallowing objects is decreasing in prison. There has been a slight change in regulations about self-mutilation. Until 1998, the law stipulated the period for medical assistance after self-mutilation did not count as part of the sentence served, from now it will count.

There has been no formal evaluation of how well the treatment programmes work. However, there is some feedback from research done in one prison in Warsaw where prisoners who have addiction problems were interviewed. The head of treatment in the Polish Prison Service is satisfied that the programmes work, based on discussions she has had with colleagues who tell her that many of the prisoners are very happy with their therapy. Colleagues from other prisons also get feedback from ex-prisoners who have continued not to use addictive substances for six months or more after release from prison.

Health promotion

Health promotion is just starting in Poland but they have the most developed strategy amongst the three countries visited. There have been many health-care reforms and they need some time to settle now. The prison health-promotion strategy is set centrally but the heads from the medical centres in the regions also add to the strategy. There are fifteen regional offices each with a head doctor.

The doctors are working towards health promotion and they go to the prisons. There is an annual meeting about the health promotion strategy for members of

the prison health service. It is a two way process of staff training and changes to policy. The health promotion strategy will introduce a methadone programme for prisoners later this year (2001). Prisoners currently receive a lot of health promotion information from the medical centres and they can also get information from the doctors during the medical examination at entry to prison.

The Polish head of prison health care aims to inform the Ministry of Health that prison provides a good opportunity to focus on health promotion and education about health (for example, TB, Hepatitis, HIV, drugs) and encourage the Ministry of Health to take responsibility for prisoners. In the area of transmittable diseases there is a TB prevention programme. Information about risk behaviour is provided at the time of entry to the prison, especially focusing on sexually-transmitted diseases. There are also some interviews with prisoners considered to be in 'at risk groups'. The prison radio is also used to provide information on risk behaviours and drugs. There is continual education using books, posters, and information. The prisoners are involved with the prison radio and it is possible for them to choose the subjects for the programmes. Videos are also used and given to prisoners to watch.

It was mentioned that it is not easy to work with health promotion strategies in prison because people think that the problem stops when prisoners are put into prison. The climate in Polish society is slowly changing.

In the Polish Prison Health Care Department, health promotion is also considered to be important for prison

staff. This year (2001) a Hepatitis vaccination programme for staff will begin. It is hoped that the Ministry of Health will pay for this for security staff, as this is a requirement for their job. It is thought that the staff will be willing to take the vaccination and they will have to pay a small part towards the cost in order for them to take responsibility for their own health care.

The second project for staff health will be an anti-smoking campaign and this will also be introduced for prisoners at a later date. They want to try to change the smoking culture of the prison: 90% of prisoners are smokers. Nationally there has been a high profile anti-smoking campaign but it is mostly educated people who are giving up. The working class are still smoking.

Previously, the health of Polish prison staff has been ignored. The prison environment is stressful and aggressive. There will be a questionnaire sent to staff to rate their stress levels and views on their health. A psychologist has been designated to work with the prison staff in each prison. The harm reduction project is designed to make their jobs easier. Alcohol reduction will be the next project.

In Hungary, there is a sexually-transmitted disease policy that requires all health care staff in prisons to educate both staff and prisoners. The Prison Health Care Department also provide several booklets that are simplified from those supplied by the Ministry of Health. There are some non-governmental organisations who provide films and videos. All prisoners have sessions in groups (some large and some small) about personal hygiene, fungus, drugs,

HIV, influenza, TB and mental health treatment. The department has a half-year work plan and the dates for the groups are made available in advance. Prevention information is included and is compulsory for both staff and prisoners. Health materials are not translated into other languages due to a lack of money. What money there is has gone to translate the prison rules.

In the Czech Republic there is a harm-reduction policy. It is one of the duties of the health care staff to provide information. Posters and discussions are also used.

All new prisoners to Czech prisons go to a special admissions wing where they stay up to two months. While there, they are informed about their rights and obligations, interviewed by a psychologist, educator and social worker. During this time, they will get harm-reduction information but there is no special policy about what information should be given. Some materials are given to prisoners. An interpreter will be provided where necessary, according to the legislation, but the availability of a translator depends on the language required.

The harm-reduction policy guidelines are set by the Czech Republic Department of Prison Health Care and a booklet is provided for the prison medical staff. Every six months there are meetings of the head doctors from all prisons and the key issues are discussed. It is thought that there is good co-operation between the different health centres in the prisons and the Department of Health Care. In Pankrac Prison, for example, there are an increasing number of foreign prisoners and some information on the prison rules

has been translated into Russian, English and Arabic. This has also happened for HIV, TB and sexual diseases. If they need a translator, they use someone from within the ministry or possibly someone from the embassy.

Prison practices affecting the health of prisoners

Cleanliness and hygiene

In Poland, it is possible for some sentenced prisoners to wear their own clothes. Women prisoners are able to have a shower every day if they want to and this is set down in the law.

In Hungary, women and juveniles can shower every day. Prisoners who work can shower every day, if they are not working they can shower once per week. Sentenced prisoners are provided with a uniform. Remand prisoners can wash their underwear where this is possible. There is a central laundry in prisons, which prisoners do not have to pay for.

In the Czech Republic, it is possible for male prisoners to have a shower at least once per week or more frequently, based on the recommendation of a doctor. Women can shower at any time. The showers in some of the prisons are not good and prisoners often demolish them, so it is a continual process of repairing them.

Prisoners can have their own clothes but they often have no money and the clothes they have are often very poor. The Czech prison administration are trying to improve the prison uniforms but they have no money for this. Prisoners can

wear their own clothes if they wash them regularly, that is, if someone brings in fresh clothes for the prisoner.

Food in prison

In the Czech Republic, there should be a nurse present (at least part time) who controls the nutrition in each prison. The nurse also controls the menu and the quality of the food. The doctor, once per week, signs the weekly menu. The doctor has to control the quality of the meals.

The food in prison is considered to be as good as on the outside. The prison service norm is to spend approximately 2 euros for raw materials per day for most prisoners and additional money for other cases, for example, pregnant women. The systems for providing special diets is the same as on the outside. There are twelve possible diets available; Czech law insists on this. It is also possible for special meals for religious requirements to be provided under special internal regulations of prisons. Attempts are made to offer a balanced diet but fruit and vegetables are expensive and not available in large quantities. Approximately one and a half euros per day are allowed for drinks.

In the Czech Republic, from 2001, kitchen hygiene will be checked by external hygienists. This used to be the responsibility of an internal hygienist. The role of the medical doctor in the quality of the food is changing now that hygienists are based in the community. Dieticians report to the Chief Medical Officer and he reports to the governor and external hygienist. The prison governor has the duty to remedy any defects reported.

About half the prison kitchens are not in good repair. This is reported to management but the lack of money means that nothing is done to solve the problem. However, the state of prison kitchens is seen as an essential issue that needs to be dealt with. The new system of inspection will mean that there will be substantial fines for sub-standard kitchens and this may help the prison service to be able to deal with this problem. In Pankrac Prison the food is considered to be good and there have been no complaints for the last one or two years. The kitchens are not new but there has been some reconstruction and some new equipment and they are cleaner now than they were before.

Food standards in Hungarian prisons are based on the norms set by the Ministry of Health, which specify the energy required for work. Prison administration officials consider that the norms are set too low and that the diet is lacking in vitamins. The variety and amount of food is, though, often more than the prisoners get outside. There are special diets available for health reasons, religion and for vegetarians.

In Poland, food is considered by the prison administration to be much better in prison than in the community. However, it is not a healthy diet. There is considered to be too much fat in the current diet in the prisons and the head of health care wishes to reduce the amount of fat. There are 2600 calories per day for those not working, if working the diet is 3200 calories plus another 1000 if doing heavy work. Nonetheless, the diet is varied and there are dieticians who prepare the menus. Medical staff check the food prior to it being served to prisoners and the menus have to be

signed by the doctor. There are also nine special types of diets prepared.

Activities and 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 opportunity for such activities varied in the three countries and was effected by the rate of overcrowding in the prisons.

In Hungary, in some remand houses, education programmes are available, usually short vocational or basic education. More than 2000 prisoners have participated in this vocational training. There are religious services in the prison and a full time priest in the remand houses. Prisoners have had access to priests since 1990. Between 5 – 10% of prisoners have asked to talk to the priests. There are 11,300 sentenced prisoners of whom 4,700 have no work (especially in winter as it is too cold to be in the fields); 2,500 prisoners are involved in education programmes. If a prisoner works, they get one third of the minimum national salary. If they take education they get one ninth of the minimum salary.

In the Czech Republic, young prisoners have access to the vocational department of the Ministry of Education and in six prisons they have a school. It is hoped to increase the number of these apprentice schools. It is mandatory for juveniles (15–18 years) to attend these schools. Those aged 18–26 years, if they need it, also have to attend these schools. There are also other courses available in each prison, basic education for adults and juveniles and other courses like Czech

language for foreign prisoners. The aim is to keep prisoners active and to make up the gaps in their education and social skills.

The overriding philosophy is that, with some prisoners, it is important to employ them in order to rehabilitate them. For other groups, for example, young offenders, it is important to provide education, which is more important for their future employment than regular employment whilst in prison. Since 1965, work and education are on the same level of importance. Prior to this education was primarily provided by evening classes after work but now it is available during the day.

It is mandatory, under Czech legislation, for sentenced prisoners in the Czech Republic to work. In reality, about 40% of prisoners are employed and there was a slight increase last year with about 1000 more prisoners being employed than in 1999. The remainder work occasionally. There should be no difference between Czech prisoners and foreign prisoners in the availability to work. Pre-trial prisoners have no obligation to work. The pay received depends on the number of hours worked, based on the minimum wage of 149 euros per month. If there is no work available, prisoners are given 2 euros per month. If they are doing education, they are not paid.

In Pankrac prison, sentenced prisoners are mainly employed on the maintenance of the prison but the numbers employed have had to be cut since the introduction of the minimum wage, the prison can no longer afford to employ them, resulting in a drop of employment from 85% to about 60%.

In 1999 in Poland, 25% of sentenced prisoners or 11,410 prisoners were working. There is an unemployment rate of prisoners of 42% of those who could be employed. The majority of the work is paid domestic work (74%). In all, 5% of prisoners are working outside the prison and 1% are involved in craftwork (activities that can be done in the cell, for example, sewing or light assembly). The activities available for prisoners in closed prisons are very limited. Prisoners who work get almost the same amount of money as they would in the community, that is, the minimum wage. The lack of work is one reason why TV is allowed in the cells and 90% of prisoners have a TV set in their cell. Small animals like birds or cats are also allowed in prison. Prisoners are not paid for doing education but they do get a small amount of pocket money.

Key issues in health provision

HIV

Currently, in the Polish prison system, there are 981 HIV-positive prisoners (2001). There is no mandatory testing for HIV on entry to the prison as prisons are part of the national project for HIV and the testing is voluntary in the same way as outside. There has to be signed consent from the prisoner for an HIV test. Not all prisoners are screened as this is considered by the prison administration to be a waste of money as all prisoners should be treated as if they are HIV positive. If a prisoner has the HIV test they get pre- and post-test counselling. Prisoners who are HIV-positive are not separated from the rest of the prison population and their status is confidential

so that even the prison governor does not know who is HIV-positive.

Prisoners in the Polish prison system who are HIV-positive are given anti-viral drugs in co-operation with the National Centre for Communicable Diseases in the community. The Ministry of Health supplies and pays for the drugs. Previously in Poland, therapy stopped when a prisoner came into prison.

In the Czech Republic, when HIV was first seen in the 1980s, risk groups of prisoners (homosexuals, prostitutes and drug users) were mandatory tested until 1994. In 1994, legislation guaranteeing anonymity and the voluntary agreement to HIV testing was adopted by the Prison Service. The only groups who are tested without consent are pregnant women, unconscious people, those accused of a sexual offence and those ordered to be treated for sexual diseases — testing for all other prisoners is voluntary. When HIV is diagnosed, the prisoner is treated the same as all other prisoners (not isolated). Prisoner confidentiality is guaranteed as usually no one knows unless a prisoner asks to be placed separately when the prison governor is then informed. The prisoner's HIV status is put in his medical file but HIV is not written rather the international code is used so good confidentiality is achieved.

Previously, prisoners' files had been seen by some unauthorised person so this use of the international code for HIV is a safeguard. There is only one person authorised to know who is HIV in the prison service and this is the doctor at the Prison Service Headquarters.

In the Czech republic HIV appears to be stable at the moment with only seven

people known to be HIV-positive out of the 21,000 prison population⁸. Between 1986–2000 in the Czech prisons 68,355 people were tested and 17 cases of HIV positive prisoners were identified.

In Czech prisons there are two steps to diagnosis of being HIV positive, first the reactive test followed by a confirmation test. When the second test is positive then the prisoner is considered to be HIV-positive. There is only one laboratory for testing. For post-test counselling the prisoner goes to special public regional centres that are mostly in Prague. The doctor arranges for post test-counselling and a treatment schedule according to the prisoner's health condition. Prisoners who are non-symptomatic stay in the prison. When the level of T cells reaches a certain level, a proposal is made by the doctor to obtain release from the prison for the prisoner. This release is not possible for prisoners with life sentences.

HIV testing is compulsory in Hungarian prisons and is part of the Ministry of Health regulations, which says that prostitutes, homosexuals and prisoners have to be tested. The testing is anonymous and forms part of the medical process at admission to the prison. Prisoners are told why the doctor is taking blood. There have only been five cases of prisoners refusing to take the test in 15 years. In the opinion of the head of Prison Health Care, they have good results. Of 14,862 tested, there have been 3 cases (2 of whom were foreigners) who were HIV-positive and there are only a total of 8 prisoners who are HIV-positive in Hungarian prisons. The system of testing and management of HIV is considered to work well in Hungary and

⁸ It was not known how many of the 21,000 prisoners had taken the HIV test.

is the reason for the low numbers of HIV-positive prisoners. However, there is prejudice, both in prison and in the community, towards people who are HIV-positive. In addition, it was felt that most prison staff did not want to work with those who were HIV-positive whereas the new unit for HIV-positive prisoners employs staff who are trained and who understand the problems of HIV.

The World Health Organisation has been pressing the Ministry of Health to change the policy of mandatory HIV testing and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) is also not happy because of prisoner's human rights — however, in Hungary the human rights organisation want this system to continue. The Prison Service's response to the CPT is that they want this system to continue. If the Prison Service went against the policy of the Ministry of Health the Prison Service would not receive the money to continue treatment for HIV-positive prisoners. When prisoners are found to be positive they are taken to a special unit in Budapest.

In Hungary, specialised treatment for HIV is only available in one hospital in Budapest. The rationale for the separation of HIV-positive prisoners is because the treatment is only available in this one hospital. All the HIV-positive prisoners receive the treatment available in the community and the NHS pays for this. These prisoners have showers in their cells, all of which are single cells. There is a community room with games and television and one social worker is available for them. There is a specialist service in the community for sexually-

transmitted diseases and the prison informs them about HIV-positive prisoners. If it is a new case, the specialist service will go to the unit with the prisoner and they will tell the prisoner the consequences of the HIV test. So there is post-test counselling provided.

Tuberculosis (TB)

In Poland TB screening has stopped in the community and TB is not spreading within the prison. On entry to the prison, there is an x-ray for TB. The incidence of TB is approximately 7 times more in prison than in the community. However, the number of TB cases in prison is going down. At the moment there is not a problem with the strain of TB that is resistant to drugs. Every prisoner is screened for TB each year. There are four TB wards in the prison health system and there are currently 274 cases of TB.

In the Czech Republic in 1999, there were 2060 cases of TB amongst prisoners and 85 cases in the TB hospital. Most (75%) of these prisoners had been tested before on previous admissions to prison. Exceptionally, a prisoner may contract TB while in prison but so far only one woman prisoner has. There are no deaths in prison due to TB as a prisoner in this condition would normally be pardoned before death.

The incidence of TB in prison in Hungary is about 4–6 times more than in the community. In 1999, there were 39 cases per 100,000 of TB in the community compared to 145 per 100,000 in prison and this has risen to 212 per 100,000 in prison in 2000. There is specialist treatment provided in the central prison hospital for TB in Budapest.

Hepatitis

The head of Health Care said that in Poland the incidence of various diseases is not always accurate as individual prisons record the number of cases manually and this can be subject to error. In general hepatitis is not considered to be a problem in the prison system. The different types of hepatitis are not separated but from next year they will be recorded separately. Overall, the incidence of hepatitis is growing. Mostly of hepatitis B and not so much of hepatitis C. This is why they are focusing on vaccinations for prisoners and staff for hepatitis B. Prisoners will be able to ask for the hepatitis vaccination in the future, especially for prisoners with a drug addiction and the vaccination hopefully will be paid for by the Ministry of Health. The co-operation with the national Ministry of Health is good and slowly the prison administration is getting them to take responsibility for prisoners' health as well.

In the Czech Republic there is a relatively high number of cases of hepatitis C in the prison system with there being 53 cases in 2000 compared to 42 cases of Hepatitis B. Hepatitis is considered to be a growing problem but not dramatic compared with the number ten years ago. The number of cases has been static for the last five years.

In the Hungarian prison system during 2000 there was 1 case of acute hepatitis A, 1 case of acute hepatitis B and 1 case of acute hepatitis C. There were 113 chronic cases of Hepatitis with 60% being Hepatitis B and 40% being Hepatitis C. It was not known if this incidence of Hepatitis was connected to drugs as the prison service do not test for hepatitis on a regular basis. If a prisoner donates

blood while in prison the blood is tested by the blood service and the prisoner will be informed if they have hepatitis.

Syphilis

In Poland there were not many cases of syphilis reported in the prison system in 2000. There were 114 cases reported which is less than 100 per 100,000. It was pointed out that this figure may be due to the way records are kept in the individual prisons.

In the Czech Republic syphilis is tracked as mandated by law and it is controlled in prisons. Each prisoner has a blood test and there has been a dramatic increase in the number of cases. Each prisoner who has a positive test result goes to Brno for treatment.

In the Hungarian prison system there were 14 cases of syphilis during 2000.

Terminally ill prisoners

Prisoners in Polish prisons who are terminally ill can ask the courts to be given sick leave to go home or to receive treatment outside in the community (if they require long term treatment) or they can ask for a break in their sentence of up to six months.

In Hungary if a patient is terminally ill the doctor may apply for an interruption of the sentence (this is a quick process) or for a pardon from the President of the Republic (but this is a slow process). In some cases prisoners do not have relatives to take care of them and this is taken into account when the decision to allow release is made. In 1999 there were 75 cases applied for and in 2000 there were 63 cases applied for. Not all of these were released. In the case of interruption

of sentence for long-term treatment, at the conclusion of the treatment the prisoner has to come back to finish the sentence. In 2000, five people were allowed interruption of their sentences.

In the Czech Republic in the case of terminal illness, a proposal is made to the court to cancel the sentence and to arrange to move the prisoner to the public hospital nearest to their home. This is not always acceptable to the courts and the courts move very slowly, but in these cases, they try to move more quickly.

Dentist and opticians

In Poland there is a dentist facility in every prison. If a prisoner needs false teeth, these can be supplied. Glasses can also be supplied by the prison medical service.

In the Czech Republic there are enough dentists in the bigger prisons and there is normally a full time dentist in sentenced prisons and a part time dentist in remand prisons.

There are enough dentists in the bigger Hungarian prisons with a full time dentist in sentenced prisons and a part time dentist in remand prisons.

The role of the prison doctor in punishments

The physician's oath is seen as being very important in Hungary. There are not considered to be problems or conflicts between health care and custodial duties. Doctors do advise on fitness for punishment when a prisoner is sent to an

isolation cell and the doctor will visit the prisoner daily while in isolation.

In Poland the doctor visits the prisoner before he or she is put into isolation and if requested a psychologist will also visit. There is not perceived to be a conflict between the doctor's health care and custodial duties. The case manager also has a duty to go twice per day to check on the prisoner. In reality isolation punishment is very rarely used now in Polish prisons.

In the Czech Republic a prisoner can be punished with up to 28 days in isolation or up to 20 days in a closed situation (23 hours locked up). Before either of these, the doctor has to sign that the prisoner is fit enough. The prisoner has a medical check up to ascertain this. The doctor then visits at least once per week and the prisoner can ask to see the doctor on other occasions. The European Prison Rules say that a doctor should visit such prisoners once per day but the above is the Czech legislation and practice.

Conclusions

The report has highlighted some key descriptive data about the health care provision in the prison systems of the Czech Republic, Hungary and Poland. Overall, there was enthusiasm for change and a continual striving to improve the quality of prisoner health care in all three systems. Staff were keen to implement the European and WHO guidelines for prisoner health but all felt that they were constrained to some extent by the prison budget. The exception was in regards to HIV and mandatory testing where despite the WHO and European Guidelines, the Hungarian prison service

was convinced that mandatory testing was necessary and that it worked.

There was awareness of changes in the wider societies, which would eventually have an impact on the prison population particularly regarding increasing drug abuse and alcoholism. The areas of drug abuse and alcoholism require constant vigilance especially when we look at the experience in prisons in Western Europe where there is a large problem with drug addiction, HIV and hepatitis C. The Hungarian Prison Service's response to drugs includes staff education, the introduction of drug free units and minimising the amount of drugs getting into prison. Dealing with drug and alcohol addiction requires the implementation of multi-disciplinary ways of working (Council of Europe, 2000). The extent and effectiveness of multi disciplinary work to combat drug and alcohol addiction in the three countries varies. For example, in Czech prisons, treatment teams work in a multi-disciplinary way in theory but this method of working is still being developed. In Poland, there is some training for staff in the first two weeks of training school. After this, once the different professional groups are working in the prison, they develop ways of working by themselves. Working effectively in a multi-disciplinary way is not always straightforward and there is a need for training to address the different professional backgrounds in order to achieve a co-ordinated approach with prisoners (MacDonald, 1999).

As yet health promotion and harm reduction is in the developmental stages in the three countries. Poland has the most developed strategy both for prisoners and for prison staff.

It is important that imprisonment should be seen as a good opportunity to encourage health promotion with hard to reach and vulnerable people. There is a tendency for prison administrations to see the health care staff as having responsibility for providing harm reduction and health promotion but this should also be the responsibility for the management and the whole prison staff. In order to provide effective harm reduction and prevention, prison administrations and individual prisons need to formulate written prevention and harm reduction strategies that address the incidences of risk behaviours occurring in the prisons. Harm reduction information should also be provided in a range of languages that reflect the prison population. In response to the increasing numbers of foreign prisoners in Czech prisons health information about HIV, TB and sexual diseases have been translated into Russian, English and Arabic for use in Pankrac prison hospital.

In all three countries sex in prison and the risks that accompany unprotected sex, particularly in male prisons, are either denied or underplayed for a variety of reasons. The first step to providing effective harm reduction and prevention is the official recognition that risk behaviour is occurring in prison. The failure to acknowledge that sexual behaviour occurs in prison prevents the effective introduction of harm reduction measures, such as making condoms available to prisoners.

Health care departments in the three prison systems are all at risk due to shortages of staff and problems about future recruitment in a situation where prison medical staff are better paid in the community than in the prison service. It

was heartening to see the variety of strategies being adopted to try to both recruit staff and to retain those already working in the system. In Poland, for example, one strategy is to train prison doctors as GPs as it is not easy to get this specialist training in the community.

The Hungarian Prison Service has developed their computer system which has greatly aided the recording of medical data especially of incidence of communicable diseases. In Poland, by contrast, such data are recorded by hand and are not totally reliable. A uniform system of collecting and analysing data should be a priority to enable prison administrations to plan effectively to meet the health needs of their prison populations.

Health care that is equivalent to that provided in the community is part of the fundamental rights of every prisoner. In all three of the countries there was considered to be equivalence of health care in prison and the community. In some cases health care in prison was considered to be better than that available in the community.

All three prison systems were experiencing overcrowding. This placed strains on staff and reduced the amount of constructive activity available to prisoners; it also impacted on the overall health of the prison population. As Tomasevski (1992:xiii) argued:

Prison health services operate under many constraints. The nature, severity and scope of prison health problems is to a large extent determined by the sentencing policies and practices. For this reason, the

prison health personnel have the unenviable task of coping with the consequences, while the causes remain beyond their reach.

It is important that the governments of the three countries visited take the responsibility to support their prison service by providing sufficient finances to enable the continuing development in the provision of a healthy environment for prisoners in accordance with international standards.

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