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**European Network on Drugs and Infections Prevention in Prison (ENDIPP)**

# Data collection to develop an inventory of social and health policies, measures and actions concerning drug users in prison in the recently incorporated Member States to the EU (CT.04.P2.329)

**Final Report**

**European Monitoring Centre**

**for Drugs and Drug Addiction**

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# A. Methodology of the Data Collection

## 1. List of Indicators and Sources of Data

Based upon the tools that had been developed by WIAD for a data collection project on prison health in Germany, a set of indicators has been drafted and presented on the occasion of an expert meeting hosted by WHO Euro and EMCDDA that took place in Riga, Latvia on 14-15 November 2004. These indicators have been discussed and agreed upon by the experts participating in this meeting.

The list of indicators now consists of four subjects (Annex 1):

1. Penal Statistics
2. General Population Epidemiology
3. Interventions Monitoring
4. Penal Epidemiology.

Data on these subjects were to be collected for the ten recently incorporated member states to the EU: Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, the Slovak Republic and Slovenia.

Most of the data on penal statistics (1.) and general epidemiology (2.) were to be found in public European data bases:

- the Council of Europe Annual Penal Statistics (SPACE I, Survey 2002 and 2003),
- the European health for all database (HFA-DB) from the Regional Office for Europe/WHO
- the end-year report 2003 (2004, No. 70) of the European Centre for the Epidemiological Monitoring of AIDS (EuroHIV) on HIV/AIDS surveillance in Europe,
- the end-year report on tuberculosis cases notified in 2002 (2004) of the EuroTB (InVS/KNCV) and the national coordinators for tuberculosis surveillance in the WHO European Region,
- the WHO Mental Health country reports on suicide.

The data on interventions monitoring (3.), on penal epidemiology (4.) and some further penal statistics (1.) were to be collected directly in the new member states to the EU. Therefore, a questionnaire had to be developed in order to conduct a survey:

- WIAD Survey 2005 (National Questionnaire on Health in Prisons).

## 2. Development of a Tool for Data and Information Collection

Based on the set of indicators and on a questionnaire already used by WIAD in previous studies (pilot testing in Germany in the 16 Federal States: a questionnaire on several aspects of prevention, harm reduction, care and other aspects related to drugs and infections in prison was sent to all Federal prison administrations, i.e. the respective Ministry of Justice), a revised tool for data and information collection was developed for the purpose of this study. Several aspects of the proposed tool needed

further clarification (e.g. definitions of “drug use”, “drug user”, “harm reduction”, “drug addiction assessment”).

The EMCDDA Protocol “Inventory of European Social and Health Policies, Measures and Actions concerning Drug Users in Prison” as well as the results and experiences with the first phase of data collection in the “old” EU member states and Norway funded by the EMCDDA and conducted by Cranstoun Drug Services were taken into consideration and used carefully to refine the methodology of the data collection and in particular the update of the questionnaire.

After undergoing a thorough internal expert rating among the involved organisations (WHO-HIPP, EMCDDA and WIAD), the draft questionnaire was finally presented and discussed with WHO and EMCDDA experts on a meeting hosted by WIAD in Bonn on 31 January / 1 February 2005. The inventory tool was revised accordingly and a pilot study could follow.

## 3. Pilot Study

Five countries were selected (Estonia, Latvia, Portugal, Romania and Slovenia) and the pilot version of the questionnaire was sent to the Ministries of Health of the pilot countries on 11 March 2005 with an accompanying letter signed by WHO Euro and EMCDDA. The Ministries of Health were asked to provide the requested data and information and send the filled questionnaire lack to the WHO Euro Office.

The pilot phase was quite successful: we received nearly complete information and data in due time (within a time period of approx. 6 weeks) from 4 of the 5 pilot countries. The pilot version of the questionnaire only needed some minor revisions (for more details, please refer to the Interim Report dated 11 May 2005), which were discussed at a meeting hosted by EMCDDA in Lisboa on 12-13 May 2005. Subsequently, a final version of the questionnaire was developed for data collection in the seven remaining new member states of the European Union. Furthermore, supplements with additional questions according to the revised questionnaire were sent to the countries of the pilot studies.

## 4. Revised Questionnaire and Data Collection in Remaining New Member States

The final questionnaire (Annex 2) covers the following aspects:

- statistics concerning the national penitentiary system,
- epidemiological data on infectious diseases (HIV, Hepatitis and TB),
- information about HIV/Hepatitis testing,
- drug substance use and mental disorders,
- prevention measures in prison,
- health care in prison,
- quality assurance in prison,

- education measures in prison,
- risk behaviour in prison.

This questionnaire was sent in May/June 2005 by the Director of EMCDDA and the Director of WHO Euro to the counterparts of WHO Euro in the seven remaining countries, which are the Ministries of Health. From there, it was then forwarded to another national authority, if necessary. We received six of the seven remaining questionnaires by Autumn 2005 (Cyprus has not answered yet). The three supplements for the pilot countries (Estonia, Latvia and Slovenia) with additional questions according to the revised questionnaire were also sent back by October 2005.

## 5. Data Processing and Analysing

According to the set of indicators, we collected data and information on penal statistics (1.) and general population epidemiology (2.) from the public European databases (SPACE I, EuroHIV, EuroTB, HFA and WHO country reports) on the one hand, and on interventions monitoring (3.), on penal epidemiology (4.) and on some additional penal statistics (1.) by means of the developed questionnaire (WIAD Survey 2005) on the other hand.

The list of indicators was used as outline for presenting the data and information collected and corresponds to the numeration of the tables, which include a detailed reference to the public data base used or the question of the questionnaire, respectively. All gathered data and information were compiled in form of comparative Excel tables (Annex 3).

The way of reporting the data combines the results of one or several items/indicators in the rows with all ten countries in the first column on the left. This method is the most adequate for country reports since it gives a good overview over the results for single countries which can always be found at the same place. Indicators are mainly presented country-wise in alphabetical order (except Tables 1.1.2.1a and 1.1.2.1c: by increasing or decreasing order).

The focus of the analysis is on quantitative data on a nation-wide macro-level aiming at an overview about a wide range of problems concerning social and health policies, measures and actions concerning drug users in prison in the recently incorporated member states to the EU. The key findings are highlighted in short comments on selected tables (from Annex 3) or graphics.

# B. Key Findings of the Data Collection

All descriptions refer to those countries which provided information. Cyprus did not respond to the call for information and for several indicators there are missing data concerning single countries. Terms like “all” or “none” of the new member states or “all countries” or “all other countries” refer only to the selected data. Indicators with very incomplete data and information are predominantly not described here.

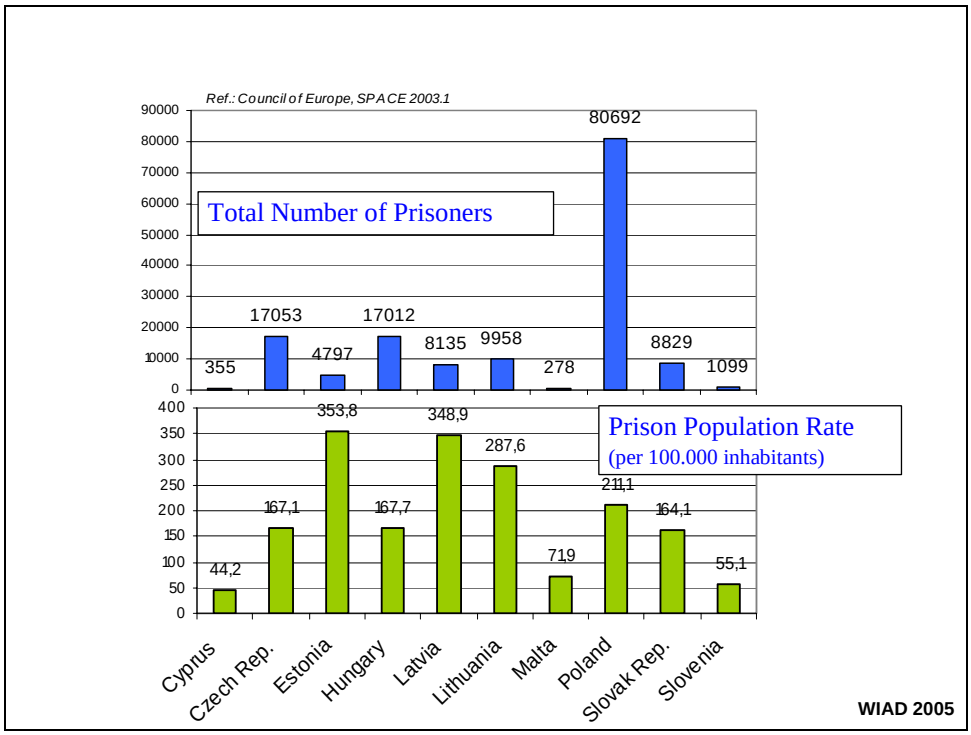
## 1. Penal Statistics

The sometimes significant differences between the new member states indicate different forms of social control regarding crime or the social definition of crime, respectively. These differences must result in differently composed prison populations and consequently have an impact on epidemiological structures and the distribution of risk groups and behaviour.

### 1.1 General

There is a significant variation of the *prison population rate per 100000 inhabitants* between Slovenia (55,1) and Malta (71,9) on the one hand and Estonia (353,8) and Latvia (348,9) on the other hand. The third baltic state – Lithuania (287,6) – also shows a high level as well as Poland (211,1)(*Table 1.1.2.1a*).

**Figure 1: Prison Population (on 01/09/2003)**



With the exception of Slovenia, Malta and Cyprus, the new EU member states have, compared to the old EU member states where the prison population rate is in average around 100 per 100.000 inhabitants, very high prison population rates.

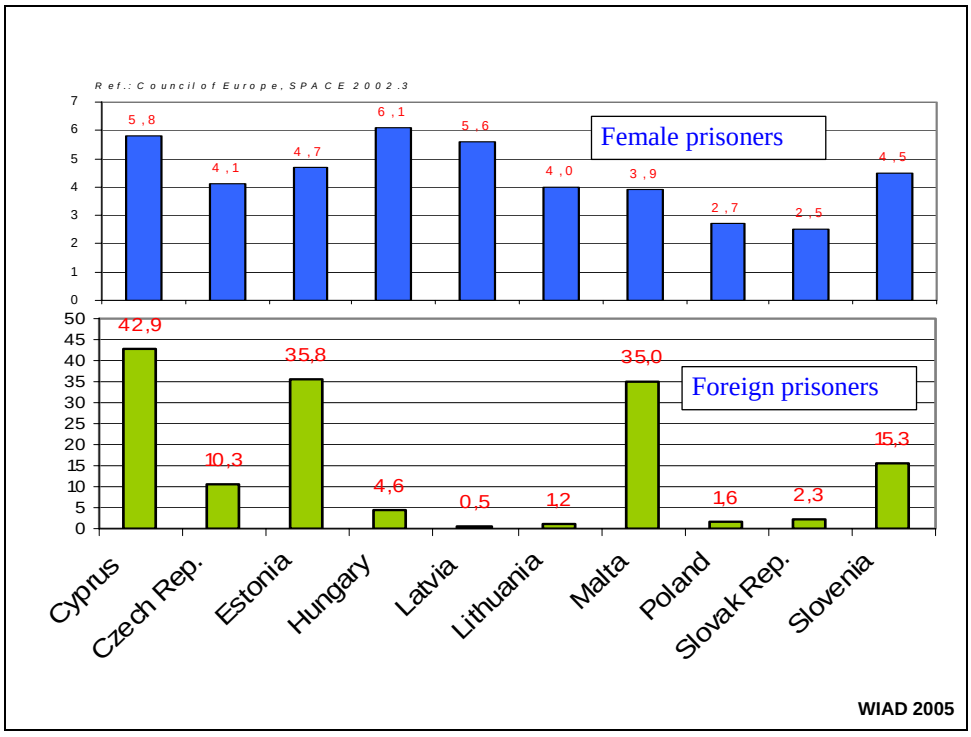
While the Slovak Republic shows a high *increase* of the *prison population rate between 2002 and 2003* (+12,5%), there is a clear *decrease* in Lithuania (-11,9%) and – less articulated – in Hungary (-5,5%)(*Table 1.1.2.1.c*).

The share of the medical costs in the total prison costs is low in Latvia (0,6%), Lithuania (0,8%) and Poland (1,1%) and comparatively high in Hungary (6,6%)(*Table 1.1.3, 1.1.4*).

## 1.2 Demographics

While there is only a little variation of the rate of *female prisoners* between the Slovak Republic (2,5%) and Poland (2,7%) on the one hand and Hungary (6,1%), Cyprus (5,8%) and Latvia (5,6%) on the other hand, the range of the percentage of *foreign prisoners* is very wide: in Cyprus (42,9%), Estonia (35,8%) and Malta (35,0%), foreigners are a strong minority, but in Latvia (0,5%), Lithuania (1,2%), Poland (1,6%) and the Slovak Republic (2,3%) they are only a small group (*Tables 1.2.1, 1.2.3*).

**Figure 2: Prison Population in % (on 01/09/2002)**



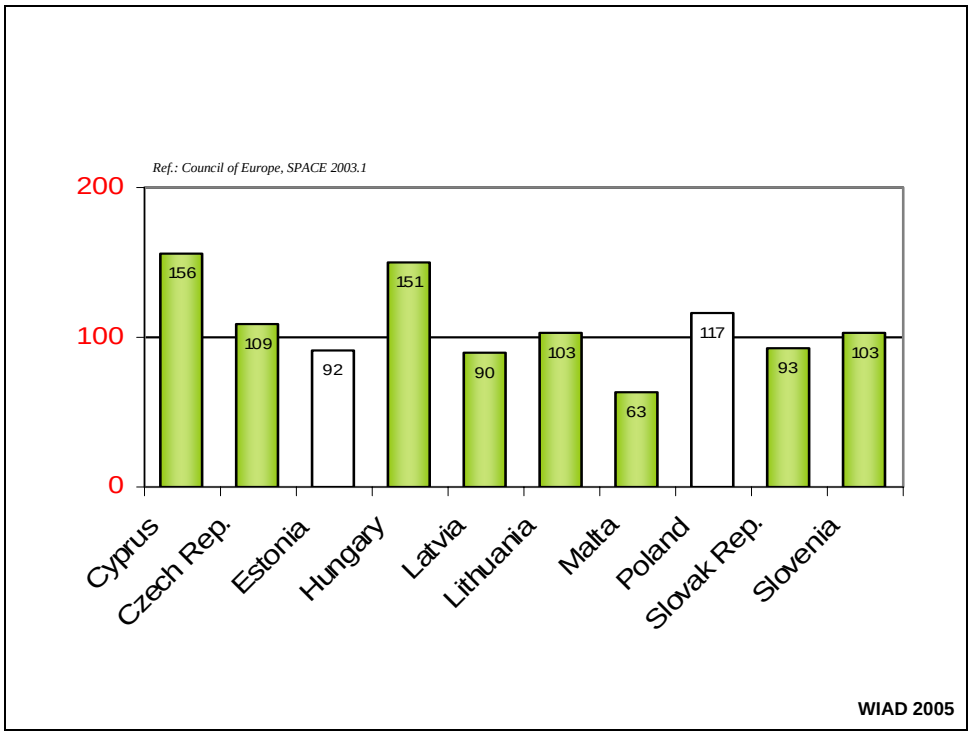

Concerning *prisoners under 18 years of age*, there is no great difference between Poland and the Slovak Republic (0,7% both) and Estonia (4,9%). The percentage of *prisoners from 18 to less than 21*

*years* varies more distinctively: low rates can be found in Malta (2,5%), Lithuania (4,5%) and Slovenia (4,9%) compared to a relatively high figure for Estonia (11,9%) and Hungary (9,2%)(*Table 1.2.2*).

## 1.3 Capacity

Most of the countries show a *prison density per 100 places* between around 90 and 110. The highest rates are to be found in Cyprus (156,4) and Hungary (150,6) and the lowest in Malta (62,6)(*Table 1.3.1, 1.3.1.1*).

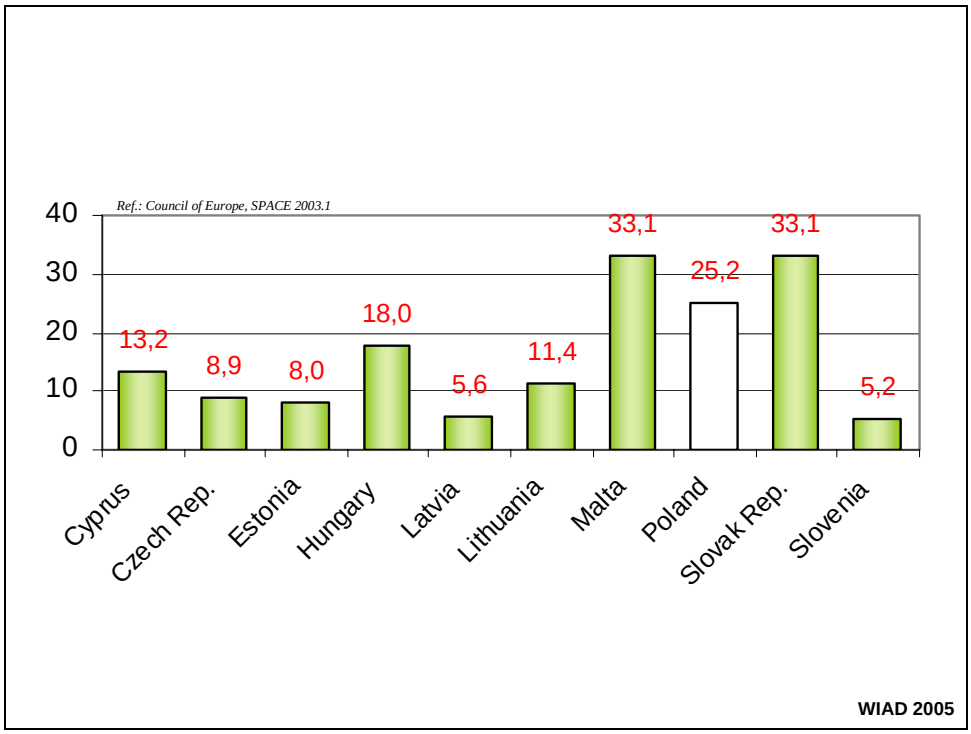
**Figure 3: Prison Density per 100 Places (on 01/09/2003)**




## 1.4 Legal aspects, offences, degree of penalty

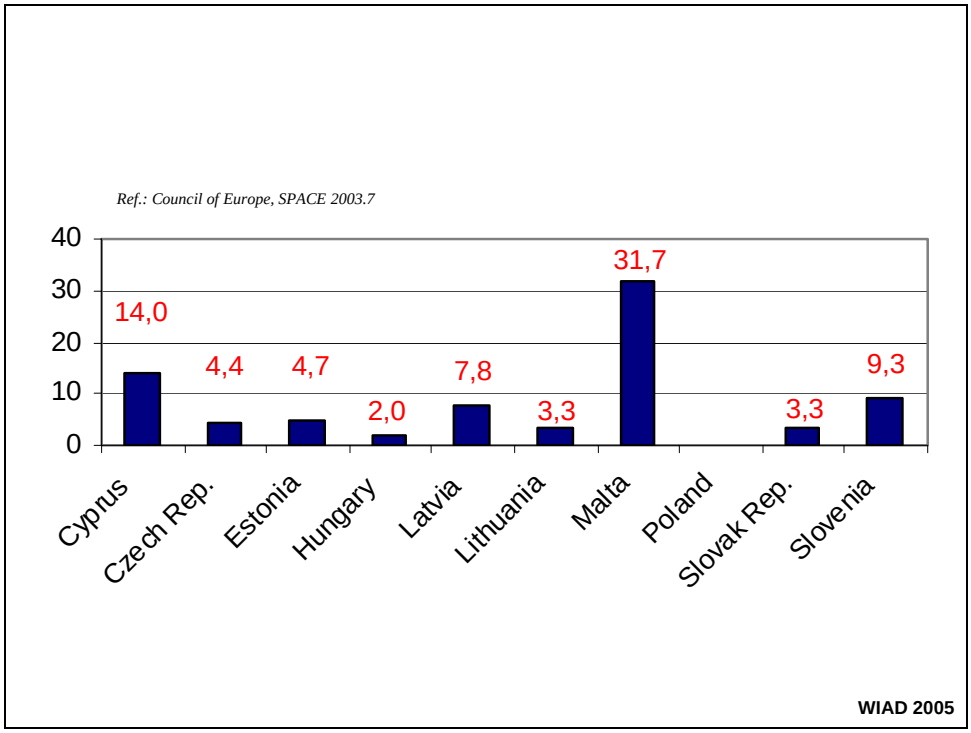
Concerning the *legal status of the prisoners*, a great variation of the percentage of untried prisoners indicate different prison populations: while in Malta and the Slovak Republic (33,1% both) a large group of prisoners is still waiting for a court decision, in Slovenia (5,2%) and Latvia (5,6%) this type of prisoners is a small minority (*Tables 1.4.2, 1.4.3*).

**Figure 4: Rate (%) of Untried Prisoners among Total Prison Population (on 01/09/2003)**




The *breakdown of sentenced prisoners by main offence* also shows great differences in the composition of the prison population with regard to drug offences: First of all in Malta (31,7%) but also in Cyprus (14,0%), drug offenders are an important group, while in Hungary (2,0%), Lithuania and the Slovak Republic (3,3% both) these crimes are of minor importance (*Table 1.4.4.2*).

**Figure 5: Percentage of Final Sentences due to Drug Offences (on 01/09/2003)**



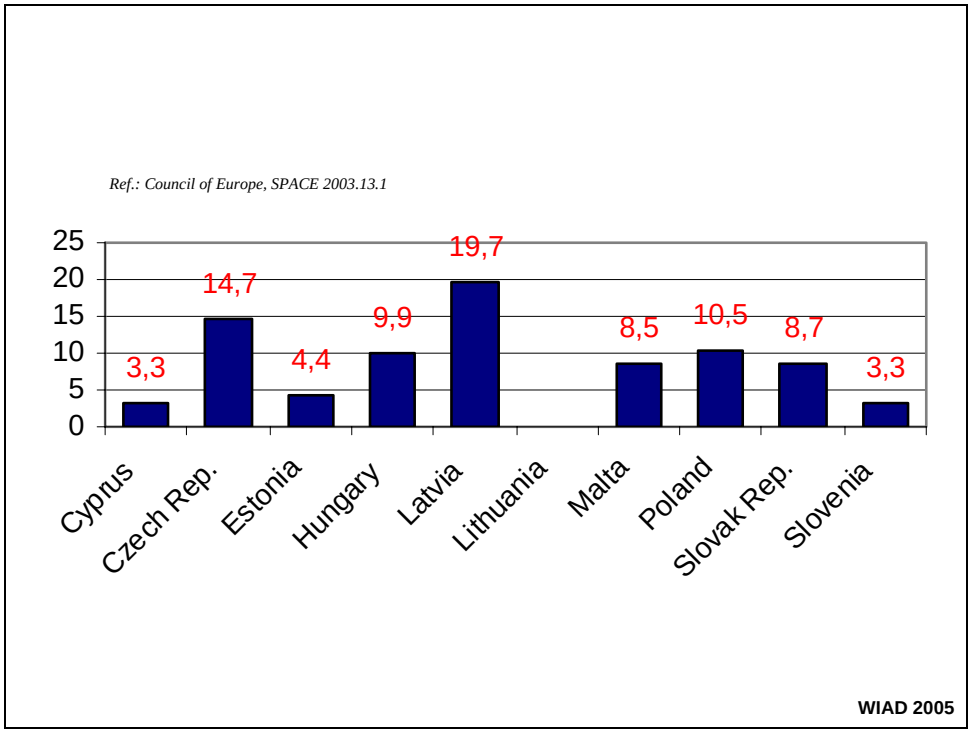

Regarding the *length of sentence*, in all new member states a vast majority of the prisoners has been sentenced to stay between 1 and less than 10 years in prison. For absolute or relative majorities, the sentence is 3 years or more in all countries. But there is a considerable range between the Slovak Republic (40,9%) and Latvia (66,3%). Those who have a sentence up to one year, have to stay predominantly six months or more, but again there are great differences with Slovenia (54,1%) and Malta (55,0%) at the bottom and Latvia (86,7%), Hungary (82,2%) and the Slovak Republic (80,3%) at the top of the rank (*Table 1.4.6*).

## 1.5 Flow of entries, length of imprisonment, escapes and deaths

The *rate of entries to penal institutions per 100.000 inhabitants* varies extremely. While Estonia shows an extraordinary figure (924,9), in the rest of the new member states there is still a remarkable difference between Poland (241,2) on the one hand and Malta (103,1) on the other hand. There is also a great range concerning the percentage of entries before final sentence: while in the Slovak Republic (19,4%) and in Slovenia (22,2%) this group of prisoners is a relative small minority, in Malta (72,4%) these prisoners are dominating the prison population (*Tables 1.5.1, 1.5.2*).

The *average length of imprisonment in months* shows again a wide range between Cyprus, Slovenia (3,3 both) and Estonia (4,4) on the one hand, and Latvia (19,7) and the Czech Republic (14,7) on the other hand (*Table 1.5.4*).

**Figure 6: Indicator of Average Length of Imprisonment in 2002 (in month)**




Concerning *deaths in penal institutions*, the figures show again considerable differences. Low – Cyprus and Malta (0 both) – or relatively low mortality rates per 10.000 prisoners in the Czech Republic (8,3), the Slovak Republic (11,5) and Poland (11,9) are in contrast to the situation in Slovenia (62,5) and also Latvia (45,8). Regarding the suicide rate per 10.000 prisoners, the figures vary between Cyprus and Malta (again 0 both), Hungary (0,6), the Slovak Republic (3,8) and Poland (5,0) on the one hand, and again Slovenia (35,7), but also Estonia (15,1) on the other hand. Finally there are great differences concerning the percentages of suicides among all deaths in prison: between a low rate in Hungary (2,6%) and high figures for the Czech Republic (92,9%), but also Estonia (63,6%) and Slovenia (57,1%) (*Table 1.5.6*).

## 1.6 Occupation rate and education in prison

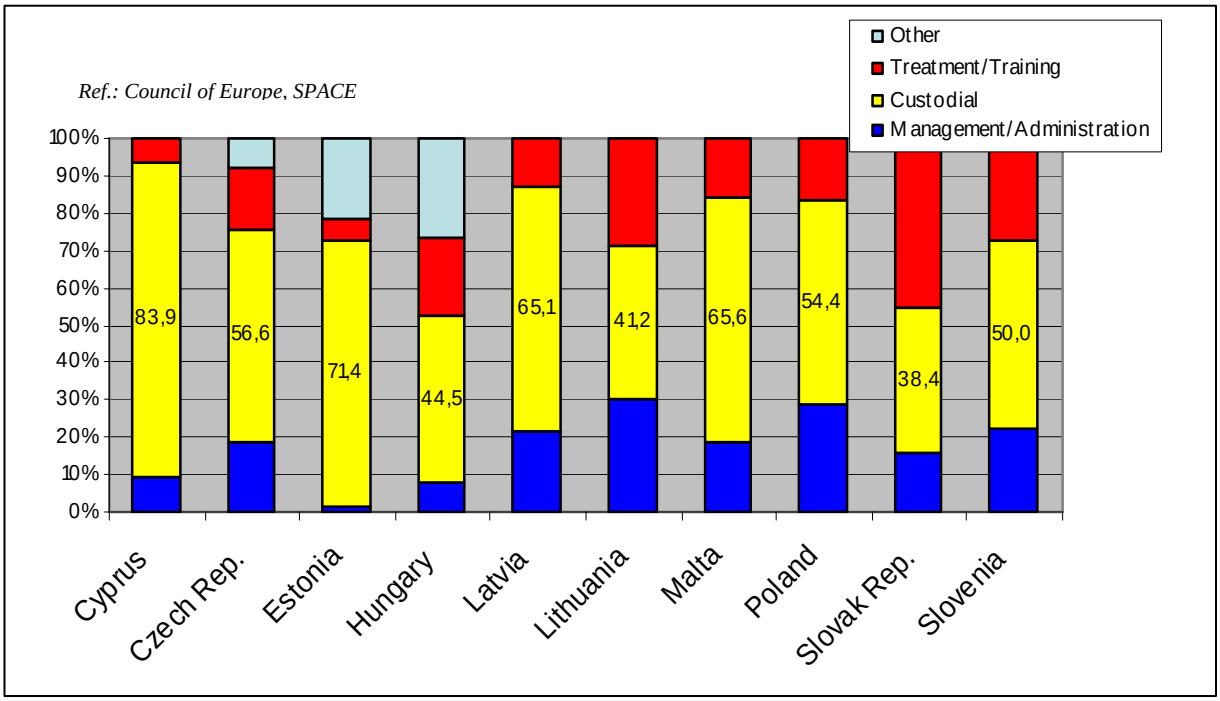
The questions on occupation, professional training and education in prison did not work very well: Only four countries provided some data regarding those questions and another problem was that the subgroups of prisoners did not sum up to the total number of (sentenced) prisoners in the respective countries so that it was not possible to calculate any rates. The only possible interpretation of the data is presented below.

The figures on *sentenced prisoners working* inside or outside prison show that predominantly the largest group of prisoners is either working more than 20 hours per week or not working at all. As far as data are provided by the countries, in general most of the prisoners attend neither *basic education courses* nor *professional training* inside or outside prison (*Tables 1.6.1, 1.6.2 and 1.6.3*).

## 1.7 Prison staff

In almost all countries, custodial staff is the largest group, but the share of custodial staff among all prison staff varies strongly between Cyprus (83,9%) and the Slovak Republic (38,4%). Only in this country, the share of treatment staff is higher (45,3%) than the percentage of custodial staff and also the highest compared to the treatment staff of the other countries. The lowest value in this category shows Cyprus (1,2%). The percentage of workshop staff differs strongly between the Czech Republic, Estonia, Poland (all zero), the Slovak Republic (0,2%) and Latvia (0,5%) on the one hand and Slovenia (16,9%) on the other hand. Lithuania (27,9%) and Poland (23,1%) show a high percentage of administration staff, while the figures are low for Estonia (0%), Hungary (4,0%) and Cyprus (5,6%). Concerning management staff, Estonia is on the bottom (1,3%) and Slovenia (6,7%) on the top of the rank (*Table 1.7.1.4*).

**Figure 7: Staff working in Penal Institutions (on 01/09/2002)**

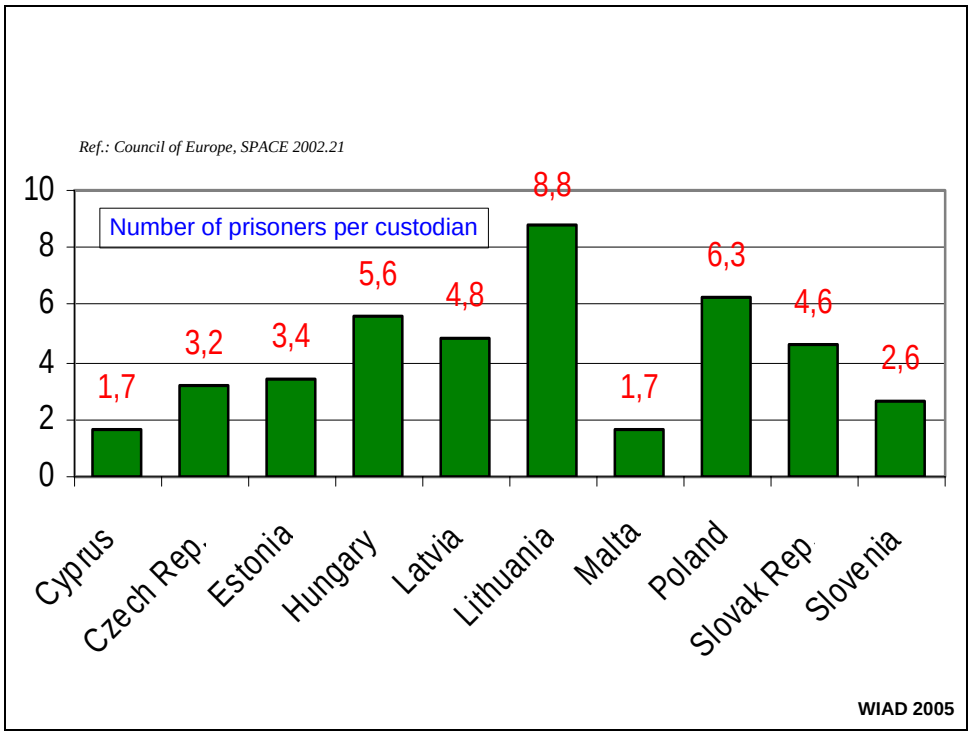



There are remarkable differences of the *rate of supervision of prisoners by custodial staff*. In Lithuania (8,8), the prison staff has to supervise about five times more prisoner than in Cyprus and Malta (1,7 both)(*Table 1.7.2*).

The *share of medical staff among total prison staff* is between three and six times higher in Estonia (9,2), Lithuania (7,5) and Poland (7,4) than in Slovenia (1,6) and Malta (2,4). Therefore, considerable differences can also be found concerning *the number of prisoners per medical worker*. In Malta a medical worker is responsible for about two times more prisoners (59,4) than in Lithuania (30,6)(*Tables 1.7.3, 1.7.4 and 1.7.4.1*).

Finally, there are remarkable differences concerning the *annual turn over rate* of prison staff between Lithuania (15,9%) and Malta (2,4%) and the *annual sick leave rate* of prison staff between Malta (6,3) and the Slovak Republic (2,6)(*Tables 1.7.5 and 1.7.6*).

**Figure 8: Rate of Supervision of Prisoners by Custodial Staff (on 01/09/2002)**



# 2. General Population Epidemiology

Major differences in the epidemiology of infectious diseases like HIV, hepatitis and other STDs in the general population have an impact on the epidemiological situation of these diseases in the respective prison settings. Due to several methodological problems, it was difficult or impossible to directly compare the prevalence or incidence data in the prison population and the general population. From the prison setting, only very little epidemiological data is available and due to the different turn-over rates, incidence data from prison (if available) is not comparable with incidence data in the general population. Furthermore, the age- and gender-distribution of the prison population (mainly men in younger age groups) differs a lot from those in the general population so that direct comparisons of rates are even more problematic to interpret.

## 2.1 HIV

Concerning *newly diagnosed HIV infections* in the year 2003, the *rates per million population* show, compared within the new EU-member states, low figures for the Slovak Republic (2,4), but also for the Czech Republic (6,0), Hungary (6,4) and Slovenia (7,1). In contrast, there is an extreme value for Latvia (174,7), but in Lithuania (31,9) the rate is considerably high, too. There is no rate available for Estonia, but a high absolute number of new HIV infections (541) for a small country. Also the *proportion of IDUs among newly diagnosed HIV infections* is on a high level in the Baltic states Lithuania (77,3%) and Latvia (54,6%). Poland (34,8%) and Malta (33,3%) have high values, too, while in the Slovak Republic and in Slovenia (0 both) and in Hungary (1,6%) the role of IDUs is of minor importance or not relevant. Regarding the *proportion of IDUs among cumulative totals of newly diagnosed HIV infections since the start of reporting*, the three Baltic states – Lithuania (80,6%), Latvia (73,0%), Estonia (71,9%) – and also Poland (58,5%) show high values. In contrast, the figures are low in the Slovak Republic (1,0%) and Hungary (1,1%). All in all, a problematic situation can be stated for the Baltic states and Poland (*Table 2.1.1 – 2.1.4*).

According to *most recent national HIV prevalence studies and diagnostic testing among IDUs* there are increased values of HIV cases in Poland (6,8%), Latvia (6,6%) and Estonia (6,2%), while no or almost no (IDU *prisoners* in the Czech Republic: 0,4%) cases have been found in the Czech Republic, Hungary, the Slovak Republic and Slovenia (*Table 2.1.5*).

## 2.2 AIDS

The *incidence rates of AIDS cases per milion population* in the year 2003 are – within the new member states – very high in Latvia (25,3), but also on a high level in Estonia (7,6). On the other end of the range are the Slovak Republic (0,4) and the Czech Republic (0,8). The proportion of IDUs among AIDS cases is extremely high again in Latvia (75,9%), but also in Poland (65,3%), Estonia (60,0%) and Lithuania (55,6%), the majority of AIDS cases are IDUs, while in the Czech Republic, Hungary, Malta and the Slovak Republic (all 0%), injecting drugs seems to be of no or minor relevance for the epidemiology of AIDS. The data on the *proportion of IDUs in the cumulative total of AIDS cases reported since the beginning of the epidemic* confirm this statement: Malta (0%), Hungary (0,4%), the

Czech Republic (1,2%) and the Slovak Republic (2,8%) show the lowest figures. In contrast, Latvia (64,8%) and Poland (51,2%) have extreme high values and also in Estonia (18,6%) and Lithuania (13,8%) the role of IDUs is important (*Table 2.2*).

## 2.3 Hepatitis

Concerning *new viral hepatitis cases* the *incidences per 100000* in 2003 are highest in Latvia (41,5), but also on an increased level in the Slovak Republic (17,9) and Estonia (12,1). A very low figure shows Malta (0,8). The *viral hepatitis A incidence per 100.000* is high in the Slovak Republic (13,9), but also in Hungary (5,5), while Lithuania (0,4), Poland (0,4) and Cyprus (0,4) show low levels. Regarding viral hepatitis B incidences per 100.000, there is a range between high figures in Latvia (14,5) and Estonia (12,8) on the one hand and low values in Malta (0,5) and Cyprus (0,7) on the other hand. The highest level of *viral hepatitis C incidences in 100000* shows Estonia (11,4), but figures are also increased in Poland (5,9) and Latvia (5,2). Malta (0), Slovenia (0,6) and the Slovak Republic (0,7) have low rates (*Table 2.3.1a – 2.3.4a*).

In 2004 again, the highest *rates of viral hepatitis A incidences per 100.000* are to be found in the Slovak Republic (11,2) and in Hungary (3,8). Malta (0), and again Poland (0,3) and Cyprus (0,6) show the lowest rates. Concerning the *rate of viral hepatitis B incidences in 100.000*, like in 2003 Estonia (9,5) and Latvia (9,2) have the highest rates. Low figures can be found for Slovenia (1,2), Hungary (1,3) and again Cyprus (1,3). The rates of viral hepatitis C incidences in 100.000 are highest in Estonia (9,3) and Poland (5,6), the same countries as in 2003. Like in the year before, the Slovak Republic (0,4), Malta (0,5) and Slovenia (0,7) have low figures, but also Hungary (0,4)(*Table 2.3.1b – 2.3.4b*).

## 2.4 Tuberculosis

The rate of tuberculosis cases per 100.000 varies remarkably between the Baltic states - Lithuania (82,1), Latvia (79,6) and Estonia (53,3) – on the one hand and the Mediterranean states Cyprus (2,5) and Malta (6,1) on the other hand. Additionally, the *percentage of multi drug resistant TB cases among drug susceptibility testing* is on the highest level in the Baltic states – Estonia (26,1%), Lithuania (22,1%), Latvia (17,7%) – while there are low figures for Malta (0), the Slovak Republic (0,6%) and Slovenia (0,7%)(*Tables 2.4.1 and 2.4.2*).

## 2.5 STDs

Concerning *new cases of sexual transmissible diseases*, the highest values are again to be found in the Baltic states. Compared to all new member states, the *syphillis incidence per 100.000* is extremely high in Latvia (33,7) but also remarkably high in Estonia (15,5) and Lithuania (13,3). In contrast, the lowest value shows Slovenia (0,6). Regarding *gonococcal infection incidences per 100.000* the figures for Estonia (39,3), Latvia (20,7) and Lithuania (14,6) are high, while Malta (1,3) and Poland (1,8) show low rates (*Table 2.5.1, 2.5.2*).

## 2.6 Violence/Suicide

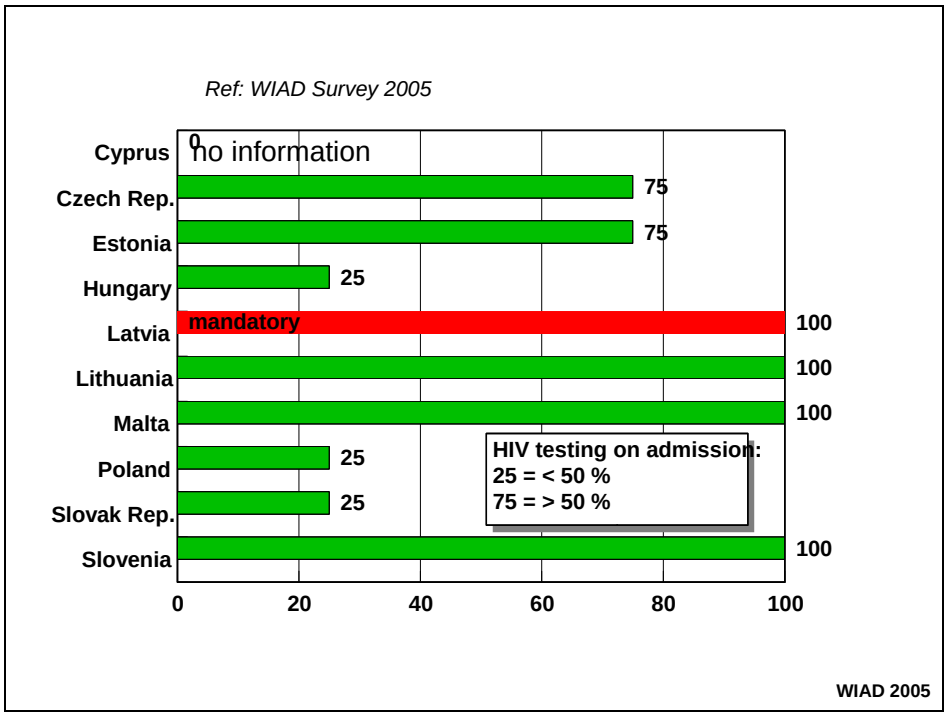
There are also considerable differences between the Baltic states and the other new member states concerning the *rate of homicide and intentional injury per 100.000* (age-standardized death rate). The highest values can be found in Estonia (10,8), Latvia (10,3) and Lituania (9,4), while the Czech Republic (1,3) and Slovenia (1,3) are at the other end of the range. The Baltic states are also in the group with the highest values regarding suicide mortality rates per 100.000. Lithuania shows an extreme figure (44,7), followed by Latvia (28,6), Hungary (28,0), Estonia (27,3) and Slovenia (27,1). In Malta, the rate is only (4,8)(*Table 2.6.1, 2.6.2*).

# 3. Interventions Monitoring

## 3.1 HIV/Hepatitis Testing

In general, *HIV testing of prisoners on admission* is conducted in all countries, but only in Latvia, Lithuania, Malta and Slovenia for all prisoners. The Czech Republic and Estonia test more than 50%, while Hungary, Poland and the Slovak Republic test less than 50%. With the exception of Latvia, where testing is mandatory for all prisoners, participation in all other countries is voluntary (*Table 3.1.1, 3.1.1.1*).

**Figure 9: HIV Testing policy on admission**




100 % mandatory testing might make sense, if prisoners are also tested on release, which is not the case for Latvia (they do not test anybody on release) or if the HIV prevalence or incidence is extremely high in the country (which is not the case for Latvia: cumulative totals ever reported AIDS cases in the country is 320, in 2004, 91 cases were newly reported, which is 40 per 1 Mio population; in 2004 there were 323 HIV cases newly diagnosed in Latvia, which is 140 per Mio population).

In Hungary, all suspected, diagnosed and self reported drug users are tested for HIV on admission, but not on release. This testing policy is hard to understand, since the proportion of IVDU among newly diagnosed HIV cases in Hungary is very low (1,6%).

In most of the countries, there is no *Hepatitis B testing on admission*. Only Malta and Slovenia test all prisoners. The Czech Republic does so for the majority of them. While in the latter the test is mandatory for all risk group, in the former the test is voluntary (*Table 3.1.2, 3.1.2.1*).

In the majority of the countries, there is no *Hepatitis C testing on admission*. Again Malta and Slovenia test all prisoners and the Czech Republic more then 50% of them. Additionally, the Slovak Republic test less then 50%. In the Czech Republic testing is mandatory for all risk groups, in the other countries it is voluntary (*Table 3.1.3, 3.1.3.1*).

There is no *HIV testing on release* in most of the countries, only Lithuania tests all prisoners, while Estonia test a minority of them. In both countries the test is voluntary (*Table 3.1.4, 3.1.4.1*).

The new member states provide neither *Hepatitis B testing on release* nor *Hepatitis C testing on release* (*Tables 3.1.5 and 3.1.6*).

*HIV pre- and post-test counselling* takes generally always place in most of the countries, but in the Czech Republic and the Slovak Republic generally only in case of a positive test result (Table 3.1.7).

In all countries *national standards or guidelines on HIV testing* are available which are also applied in prisons (*Table 3.1.8*).

*National standards or guidelines on Hepatitis testing* are available in a majority of the countries: The Czech Republic, Estonia, Hungary, the Slovak Republic and Slovenia have them and almost all apply them in prison, too (*Table 3.1.9*).

## 3.2 Substance use

*Prisoners are tested for drugs* in most of the countries in all prisons, in Hungary and Poland only in less than 50% of the prisons. The predominantly used kind of testing is always urine testing (*Table 3.2.1*).

Concerning the *drug testing practice applied in prison*, most of the countries do not test on admission, but the Czech Republic, Malta and Slovenia do so in all prisons. There is also no testing before holidays/weekend leaves with the exception of Malta and Slovenia, where testing in all prisons is performed. Almost all countries test in all prisons by suspicion of drug consumption, only Poland does so in less than 50%. In a majority of countries, drug testing is performed per random routine in all prisons, in Hungary only in less than 50%. Latvia, Lithuania and Poland do not test per random routine (*Table 3.2.1.2*).

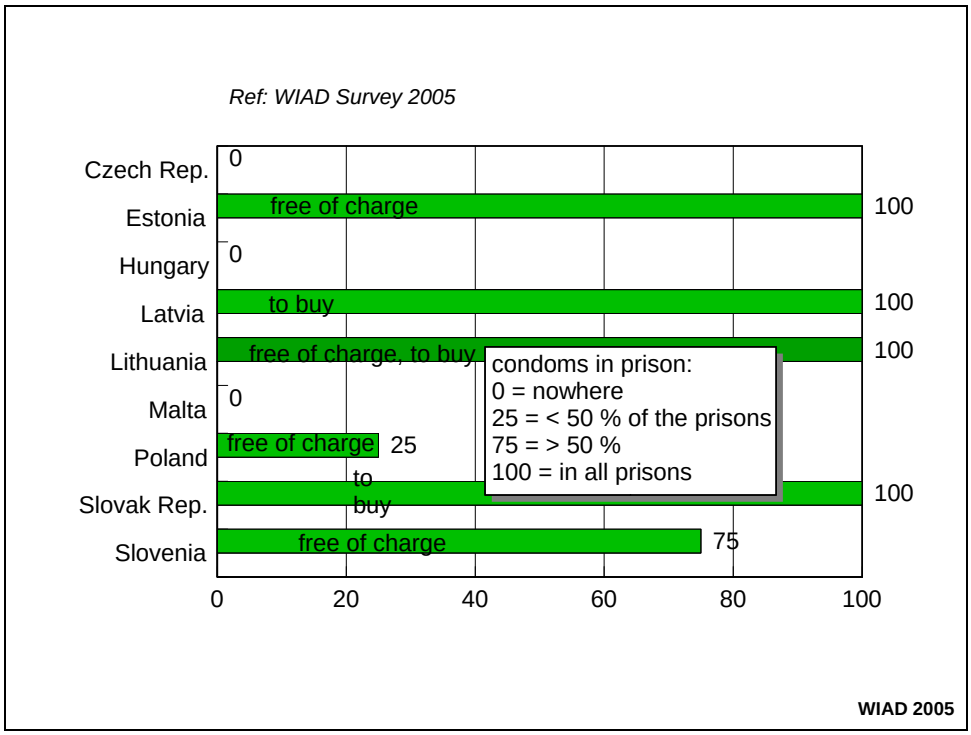
## 3.3 Prevention

In none of the new member states are *needle/ syringe exchange programmes for IDUs implemented in prisons* (*Table 3.3.1*).

In most of the countries *condoms are available in prison*: in Estonia, Latvia, Lithuania and the Slovak Republic in all prisons, in Slovenia in more than 50% and in Poland in less than 50%. They are mostly

free of charge (in Lithuania only for long term visits) with the exception of Latvia and the Slovak Republic, where prisoners have to buy condoms (*Table 3.3.2*).

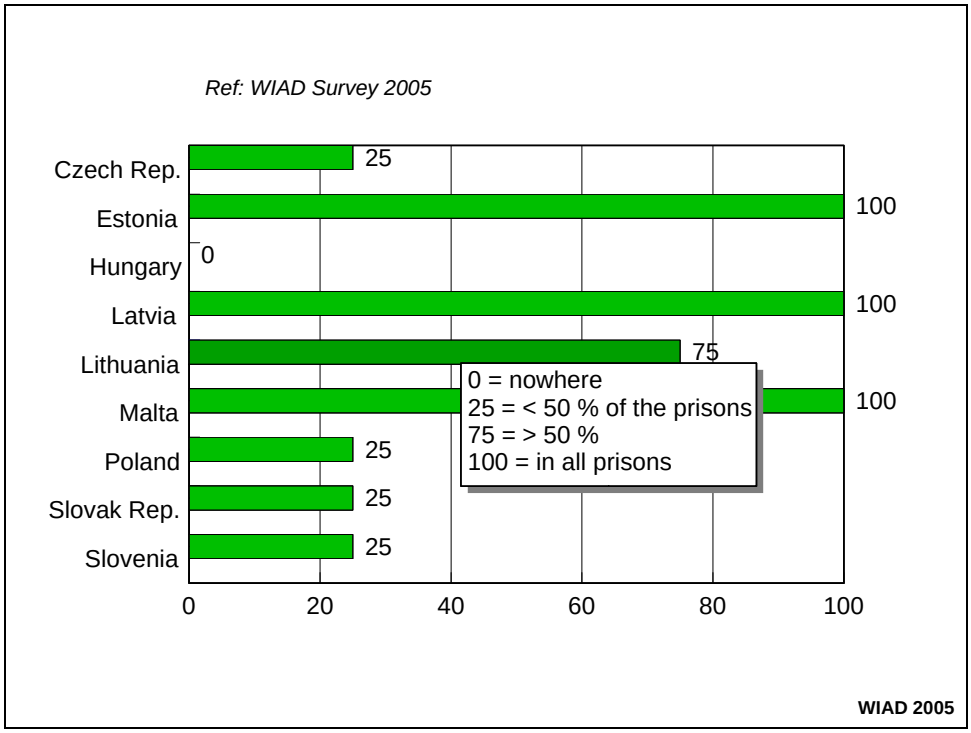
**Figure 10: Condom Availability**




In the majority of the new member states, *disinfectants (bleach)* are not *available in prison*. Only Estonia and Slovenia provide them in all prisons and Lithuania in less than 50%. The kind of disinfectants provided is solution; information/ guidelines for using them are available in all prisons of Lithuania and Slovenia, but not in Estonia (*Table 3.3.3*).

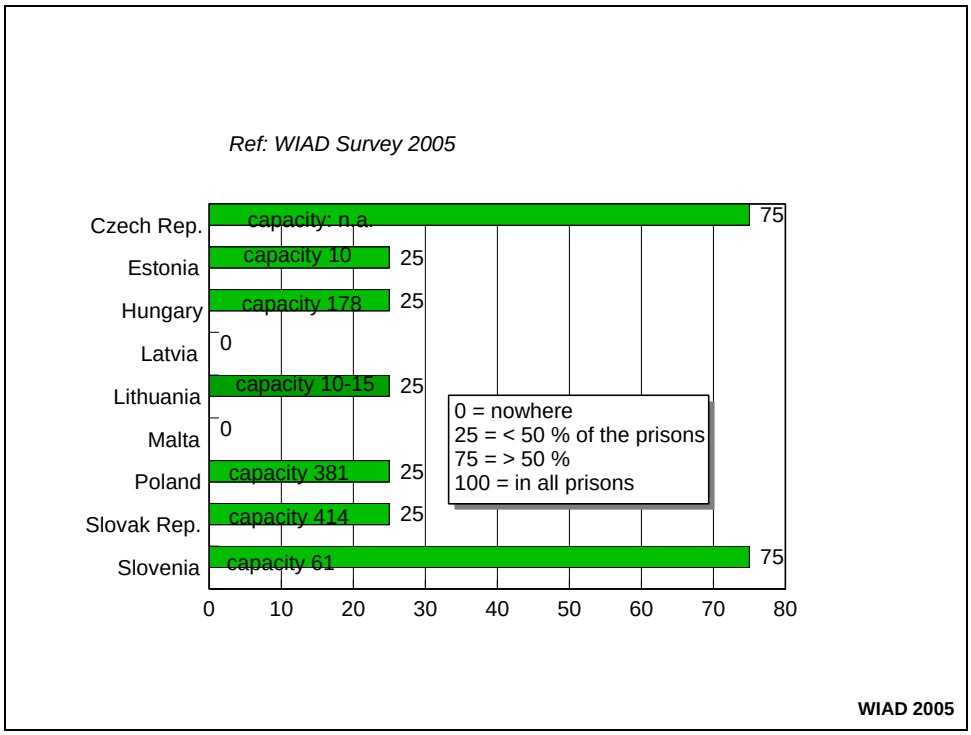
The *possibility of non-supervised family/ partner visits in prison* exists in almost all countries, but only in Estonia, Latvia and Malta in all prisons. Lithuania offers this possibility in the majority of the prisons, while the Czech Republic, Poland, the Slovak Republic and Slovenia do so in the minority of them (*Table 3.3.4*).

**Figure 11: Non-supervised Family/Partner Visits**




Predominantly, *drug free units in prison* are *available*, but only in the Czech Republic and Slovenia in more than 50% of the prisons, while Estonia, Hungary, Lithuania, Poland and the Slovak Republic offer them in less than 50% (*Table 3.3.5*).

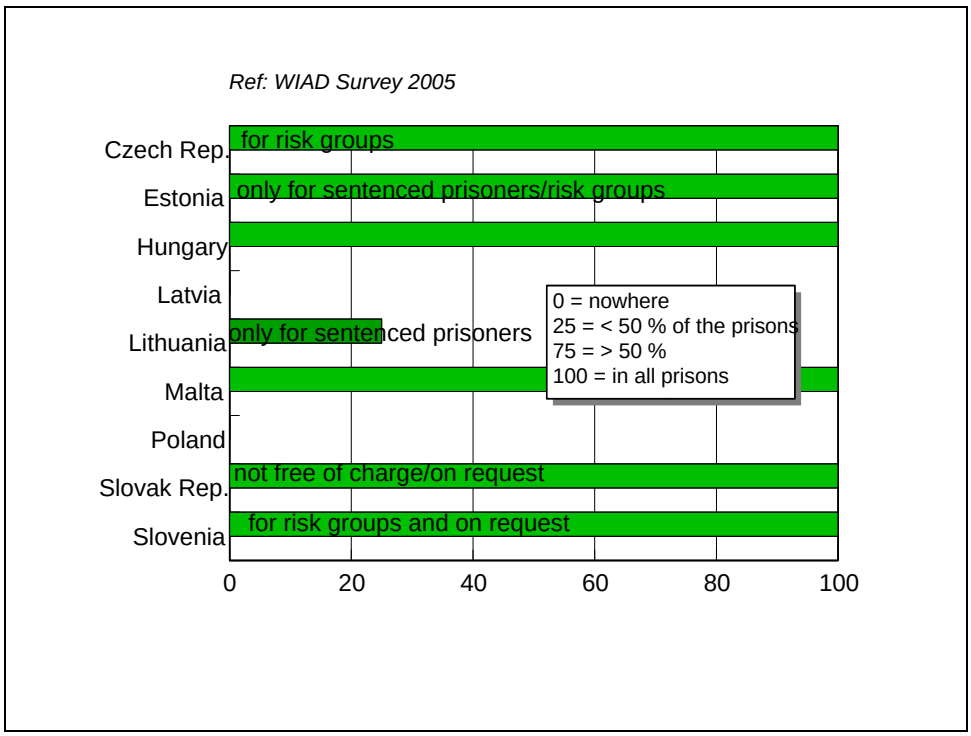
**Figure 12: Drug free units in prisons**



With the exception of Latvia and Poland most of the countries provide the *possibility of vaccination against Hepatitis B*, generally in all prisons, but in Lithuania only in less than 50% of them (*Table 3.3.6*).

*Circumstances of vaccination* against Hepatitis B are different in the new member states: If vaccination is available, it is predominantly free of charge with the exception of the Slovak Republic. Concerning the legal status of prisoners, this possibility is offered generally to sentenced and other prisoners, but in Estonia and Lithuania only to sentenced prisoners. Regarding medical aspects only Malta offers vaccination against Hepatitis B to all prisoners, the Czech Republic, Estonia and Slovenia to risk groups and Hungary, the Slovak Republic and Slovenia only on request (*Table 3.3.6.1 – 3.3.6.4*).

**Figure 13: Availability of Hep B Vaccination**




## 3.4 Care

Concerning the *availability of antiviral treatment for Hepatitis C positive prisoners*, the situation in the new member states is polarised: there is either no possibility (in Estonia, Hungary, Latvia, Malta) or it is available in all prisons of the majority of the countries. But where the data is available, the relation between the number of positive prisoners and the number of those under treatment (Poland and Slovenia) is quite low (*Table 3.4.1*).

*Antiretroviral treatment for HIV positive prisoners* is *available* in all prisons of all countries. Again, some of the given data reveal a low rate of positive prisoners under treatment (Czech Republic, Latvia, Lithuania, Poland)(*Table 3.4.2*).

Regarding the *availability of drug related treatments in prison*, brief detoxification with medication (<10 days) is performed in almost all countries: in Hungary, Latvia, Malta, the Slovak Republic and Slovenia in all prisons, in the Czech Republic, Lithuania and Poland in less then 50%. While prohibited by law in Hungary, brief detoxification without medication (cold turkey) is not provided in Lithuania, Malta and the Slovak Republic. Drug free treatment with psychosocial support is not provided in Latvia and Malta and in the other countries only in the minority of the prisons. Only Latvia states availability in all prisons and the Czech Republic in less than 50%. Treatment with antagonists exits only in the Czech Republic and there only in less than 50% of the prisons. There is no substitution treatment in most of the countries, in Latvia it is prohibited by law. Only Hungary and Malta offer substitution treatment in all prisons, additionally Poland in less than 50% (*Table 3.4.3*).

Only Hungary, Malta, Poland and Slovenia[1] offer substitution treatment. The total numbers of prisoners under substitution treatment are generally low, and, as a rule, the treatment is accompanied by psychosocial interventions. Substitution treatment for acute detoxification is available in Malta, Poland and Slovenia. The same countries and Hungary offer it also for prisoners being under substitution treatment before entering the prison, in all cases without a time limit. Substitution maintenance therapy is possible for all prisoners in Malta and Slovenia, in Hungary only for those prisoners under substitution treatment before entering the prison (*Table 3.4.3.1 – 3.4.3.3*).

Concerning *external health services offered in prison*, the situation is different depending of the kind of service. Drug services exist in most of the countries, i.e. in all prisons of the Czech Republic, Lithuania and Malta, in more than 50% of Hungary´s prisons and in less of 50% of the prisons in Poland and Slovenia. Only Poland and the Slovak Republic do not offer external HIV services. In Slovenia, they exist in less of 50% and in Hungary in more than 50% of the prisons. In the other countries, they are available in all prisons. The majority of the countries does not offer mental health service from outside, Hungary and Lithuania do it in less than 50% of the prisons, the Czech Republic and Slovenia in all. Other health services are provided in most of the countries, i.e. in all prisons in the Czech Republic, Hungary, Latvia, Malta and Poland and in less than 50% of Estonia´s prisons (*Table 3.4.4 – 3.4.7*).

Also, the *availability of drug-related pre-release interventions* in prison vary with the kind of this interventions. With the exception of Malta, information dissemination as well as counselling on increased risk and prevention take place in all countries. While Latvia provides this offer in less than 50% of the prisons, the other countries do it in all prisons. In most of the countries, there is no initiation of substitution treatment, only Poland offer this intervention in less than 50% of the prisons and Slovenia in all. Referral to outside drug services exists in all prisons of the Czech republic, Malta, the Slovak Republic and Slovenia and additionally in the majority of Hungarian prisons, but not in the other countries. The majority of the new member states provides through care, i.e. the Czech Republic, Malta, Poland and Slovenia in all prisons and Hungary in most of them (*Table 3.4.8*).

In the Czech Republic, Malta, Poland and the Slovak Republic, *referral of mentally disordered prisoners to outside mental health services after release* is provided in all prisons, in Hungary and Latvia not at all (*Table 3.4.9*).

[1] Slovenia did not respond to the direct question on substitution, but gave information concerning details of this treatment.

## 3.5 Quality Assurance

*National standards/ guidelines for drug related treatment* are available in the community in all countries with the exception of Malta, where specific standards/ guidelines in prison do not exist either. The national standards/ guidelines are *applied to prison* with the exception of Latvia, which does not have specifics in prison, either, and Lithuania, where such specific standards/ guidelines are available as well as they are in Hungary and the Slovak Republic.

*National standards/ guidelines for the reduction of drug related harm* are available in the community in all countries with the exception of Latvia and Malta. Four countries state their *application in prison*: the Czech Republic, Poland, the Slovak Republic and Slovenia, and again four countries have specifics in prison: the Czech Republic, Estonia, Lithuania and the Slovak Republic (*Table 3.5.1, 3.5.2*).

All countries have *national standards/ guidelines for the medical management of HIV*, and the majority also *for the medical management of Hepatitis C*, only Estonia, Latvia and Malta have not. Again in all countries *national standards/ guidelines for TB screening, TB treatment and care, referral of TB patients* and *for the release of TB patients* exist (*Table 3.5.3*).

A *national standardised data collection system on prison health* is *implemented* in Estonia, Hungary, Lithuania, Poland and the Slovak Republic, in the other countries not (*Table 3.5.4*).

## 3.6 Education

The *availability of measures to prevent drug-related harm and/or infectious diseases for prisoners* vary again regarding the type of measure. Distribution of information material takes place in all prisons in all countries with the exception of Malta. There is counselling and advice by drugs and/or health professionals in all prisons of almost all countries, only in Estonia it is restricted to a minority of prisons. Peer education programmes exist in all prisons of the Czech Republic, in the majority of Lithuania´s prisons and in less than 50% of the prisons in Estonia, Hungary, Latvia and Poland. Most of the countries have no safer injecting/ safer use training for drug users; only the Czech Republic declares this for all prisons and Estonia for the majority of them (*Table 3.6.1*).

*Specific information/ education/ counselling programmes/ interventions on drug problems, risk behaviour and infectious diseases for prison staff* are *available* in all prisons of all countries (*Table 3.6.2).*

## 3.7 Additional Indicators

In almost all countries, the Ministry of Justice is *responsible for health in prison*, in Hungary and Lithuania together with the Ministry of Health. Only in Malta, the Ministry of Health alone is responsible for health in prison (*Table 3.7.1*).

The *costs for the medical treatment of prisoners* are *covered* in all new member states by the Ministry of Justice, in Hungary together with the Health Insurance and other organisations, in Latvia together with the Ministry of Health, in Malta together with the Ministry of Interior and in the Slovak Republic together with the Health Insurance (*Table 3.7.2*).

# 4. Penal Epidemiology

The data and information on penal epidemiology (cases of HIV, hepatitis, syphilis, gonorrhoea and TB and on mental disorders) in *Tables 4.1.1 to 4.4.3* are difficult to interpret. First of all we have quite many missings in these tables, meaning that countries either did not have these data or did not report them.

Comparisons between countries are difficult to perform, not to say impossible, because in order to be able to compare we have to have rates (incidence or prevalence), which we could only calculate, if we had prevalence data for a given date. Most of these countries reported new cases for a period (mainly one year). Due to different turnover rates in these countries, it is not possible to calculate incidence data. Apart from this problem, the different testing policies applied in prison and the differences in the reporting systems, are reasons which make comparisons between countries impossible.

On the other hand, as already mentioned in chapter 3 it is also very difficult to compare epidemiological information from prison with epidemiological information reported for the general population.

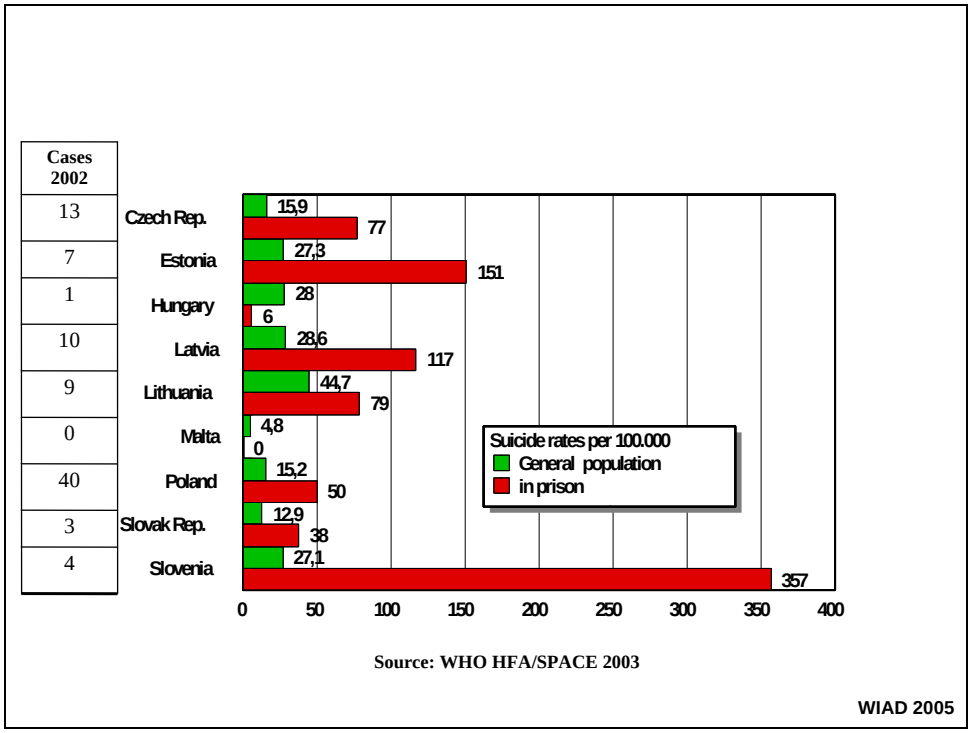
As for HIV infections reported in prison, it is striking that Estonia reports 163 new HIV infections diagnosed in prison in the year 2004. In relation to the prison population of around 4.900 (on a given date) this is a very high number.

For Poland it is striking that quite a high proportion (around 20%) of all newly diagnosed HIV infections in the year 2004 are reported from prison. The prevalence rates of HIV infection are obviously much higher in prison than outside (the rate of newly diagnosed HIV cases for the year 2004 per million population in Poland is 17,0 – if we relate to the 119 newly diagnosed HIV cases from prison to the prison population on a given date, we would get a rate of 1.441).

As regards information on risk behaviours in prison (intravenous drug use, tattooing and piercing) we can not draw any conclusions or carry out comparisons, because hardly any data was available or reported by the countries (*Table 4.5.1 – 4.5.4*).

The comparisons between suicide rates inside and outside prison are difficult due to the same methodological problems as already mentioned above. If we relate the reported suicide cases to a million prison population (which is of course fictional) it becomes obvious that we have (apart from those countries with small prison populations and very little case numbers) much higher suicide rates inside prison than in the general population. Again, this has to be interpreted carefully, because the age- and gender-distribution of prisoners differs significantly from those in the general population (*Table 4.6.1 – 4.6.4*).

**Figure 14: Suicide rates inside and outside prison**




According to *the regulations regarding tattooing in prison* tattooing is prohibited in almost all new member states. Only in Slovenia it is generally permitted (*Table 4.5.5*).