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HPYP
Health Promotion for Young Prisoners

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Comprehensive literature review

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1. International background

The administration and management of youth justice is a highly political issue throughout the European Union, and the development of policy to address the wide range of concerns regarding young people, drug and alcohol use and offending is subject to constant review (Goldson, 2000).

An important concept in the development of juvenile justice is that of welfare versus punishment, which emphasises the difference in response to juvenile offending as compared to adult offending.

Sentencing for juveniles in many European countries tends to focus more on protecting and maintaining the welfare of juvenile offenders and supporting them in their rehabilitation, compared to sentences for adult offenders, the aims of which are often geared towards deterrence, incapacitation and punishment.

Subsequently, custodial sentences are viewed as a last resort, to be used only for those juvenile offenders who have failed to respond or comply with community based penalties, who have committed serious offences or who are identified as persistent offenders (MacDonald et al 2006).

Providing health promotion to young prisoners in whatever institutions they are housed is a valuable opportunity to develop initiatives to identify and tackle the wider health needs of this vulnerable and socially excluded population.

As the UK Department of Health argues:

> *They could, for example, be given information on health services and how to use them as well as information and support aimed at influencing their drug and alcohol and tobacco usage. Even if this did not persuade them to stop it might influence them towards less risky behaviour, such as not injecting and adopting safer sexual practices* (DoH, 2005).

Further it is argued that health promotion should permeate every aspect of the work of an institution and should take in the wide range of issues which have a health dimension.

It is problematic to compare youth justice systems in different countries due to the way crimes are classified and the extent to which aspects of youth justice are recorded (Muncie, 2004). The term juvenile and young person may refer to different age groups in different countries as may the age of criminal responsibility. Most European systems treat young offenders under 21 years of age differently. Across Europe, there is growing concern about the threat of youth crime despite the research that indicates that rates of youth crime have stabilised or are decreasing. In many countries young people from ethnic minorities are over-represented in custodial settings. The Howard League for Penal Reform (2008) provides examples of this from the Netherlands and Belgium. In the Netherlands, for example, over half the population in youth detention centres are

not born in the Netherlands and in Belgium there has been concern about crime that is attributed to young people from ethnic minorities resulting:

> *in pressure to introduce a juvenile justice system in which children are held more accountable for their actions. Despite the age of criminal responsibility being set at 18, children even younger than 12 years of age can be placed in secure centres in exceptional circumstances. Further, a new law passed in the wake of the murder of a teenager by two other teenagers in 2006, allowed for the creation or a large new prison for 16 and 17 year olds* (Howard League for Penal Reform (2008)

There are, however, a range of international treaties and agreements that provide standards for how children who break the law should be treated. The key standards that are pertinent to young people are as follows[1].

The 1966 **International Covenant on Civil and Political Rights (ICCPR)** sets out the principle that young prisoners should be kept separate from adults in custodial settings and also that no convicted prisoner under the age of 18 can be executed.

The 1989 **United Nations' Convention of the Rights of the Child (UNCRC)** the key articles of concerning youth justice are Articles 3, 37 and 40. Article 3 provides that in all actions concerning children, whether undertaken by public or private social welfare institutions, Courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration [subsection 1]. Article 37 provides for minimum standards in treatment and punishment of juvenile offenders, to ensure that 'no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.' In addition Article 37b states that 'no child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time'. Article 40 recognises the welfare, dignity and privacy of the child by ensuring that parties treat children 'in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.'

The following treaties and agreements also provide standards for the treatment of young persons and reinforce UNCRC:

- **United Nations Standard Minimum Rules for the Administration of Juvenile Justice** 1985 (Beijing Rules);

[1] The following list of treaties and agreements draws heavily from the Howard League for Penal Reform, 2008, *Punishing children A survey of criminal responsibility and approaches across Europe*, London, Howard League. http://www.howardleague.org/fileadmin/howard_league/user/online_publications/Punishing_Children.pdf. Accessed 26/7/010

- **United Nations Rules for the Protection of Juveniles Deprived of their Liberty** 1990 (JDLs);
- **United Nations Guidelines for the Prevention of Juvenile Delinquency** 1990 (Riyadh Guidelines).
- **The Council of Europe** has also produced detailed recommendations as to the appropriate treatment for children **(Recommendation (2003) 20 of the Committee of Ministers).**

The extent to which international rules and guidance are adhered to is variable in different countries.

2. Juvenile prison population in the HPYP partner countries

2.1. Definition youth/young person

The UN Convention on the Rights of the Child definition covers children and young people up to age 18. However, for the purpose of the HPYP Project, a broader definition is used to include the transition period from youth custody to adult custody. Young women and men up to the age of 24 are therefore included.

2.2. Age of criminal responsibility

The UK has one of the lowest ages of criminal responsibility in the EU. The lowest is Scotland where the age is 8 years and England and Wales where the age is 10 years. In the rest of the EU, the age of criminal responsibility varies between 12 and 16 although in Belgium and Luxembourg the age is 18 (Table 1).

Table 1: Ages of criminal responsibility across the EU

Country	Minimum age of criminal responsibility
Austria	14
Belgium	18 (16 for serious offences)
Bulgaria	14
Czech Republic	15
Denmark	15
England and Wales	10
Estonia	14
Finland	15
France	13 (but educational measures can be imposed from the age of 10)
Germany	14
Greece	13 (but educational measures can be imposed from the age of 8)
Hungary	14
Iceland	15
Italy	14
Latvia	14
Lithuania	14
Luxembourg	18
Netherlands	12
Northern Ireland	12
Norway	15
Poland	13
Portugal	16
Romania	14
Russian Federation	14
Scotland	8
Slovakia	14/15
Spain	16 (14 in Catalonia)
Sweden	15
Turkey	12

Source: Howard League for Penal Reform, 2008

In the following, further details on the criminal responsibility in the partner countries will be outlined.

Table 2: Specifications of criminal responsibility in partner countries

Country	Minimum age of criminal responsibility	Limited criminal responsibility/ Juvenile Law	Full criminal responsibility
Bulgaria	14 years	14-<16 years	16 years and older
Czech Republic	15 years	15-<18 years (Juvenile Act)	18 years and older (18-<21 mitigating circumstances)
Estonia	14 years	14-<18 years (Juvenile Sanctions Act)	Over 18 years
England and Wales	10 years old		
Germany	14 years	14-<18 years (Juvenile Justice Law) (18-<21 years individually decided)	18 / 21 years and older
Latvia	14 years	14-<18 years	18 years and older
Romania	14 years	14-<16 years (depending on discernment of the offender)	16 years and older

Source: HPYP National literature reviews

In **Bulgaria**, under 14 years old are not criminally liable. Full criminal responsibility arises by the age of 16.

In **Czech** criminal law there is a difference made in between a *child*, which is under 15 years of age and a *juvenile*, i.e. a person between 15 and under 18 years of age at the time of the offence. C*hildren* under 15 years of age are not criminally liable. Juvenile offenders in between the age of 15 and under 18 years old are criminally liable and referred to the Juvenile Act. Full criminal liability arises by the age of 18 years; if the offender by the time of the offence was in between 18 and 21 years old this is seen as a “mitigating circumstance”.

The Penal Code of **Estonia** stipulates that a person by the age of 14 will be liable for an offence committed. Juvenile offences and also minor deviations from social regulations are processed primarily on the basis of the Juvenile Sanctions Act. For the purposes of the Juvenile Sanctions Act, a minor is a person between seven and eighteen years old. If a person in between 14 to 18 years old commits a criminal offence or misdemeanour prescribed by the Penal Code, but a prosecutor or court finds

that the person can be influenced without the imposition of a punishment or the application of a sanction, the criminal/ misdemeanour proceedings will be terminated.

In **Germany**, there is a difference made in between a juvenile (between 14 and under 18 years old) and a young adult (between 18 and under 21 years old). Under 14 years old offenders are not criminally liable. For 14 to 18 years old offenders the Juvenile Justice Law (JGG) can be applied; in this age group it again has to be verified if a person is criminally liable. If the Juvenile Justice Law or the general Penal Law is applicable for 18 to 21 years old offenders has to be individually decided depending on the maturity of the offender and the type of offence.

Latvian Criminal Law stipulates that a person reaches criminal responsibility by the age of 14. Chapter VII on the "Special Nature on Criminal Liability of Minors" applies for 14 to under 18 years old offenders.

In **Romania**, under 14 years old are not criminally liable. In the age between 14 and 16 years criminal responsibility has to be individually decided on the discernment of the offender. Offenders between 14 and 16 years old that were assessed to be criminally liable and those over 16 years old are referred to the criminal justice system.

2.3. Facilities for young offenders

In the **Czech Republic**, imprisonment of juvenile prisoners who did not exceed 19 years of age is carried out separately from other prisoners (in special prisons or in special prison wings for juveniles). When young prisoner reach 19 years of age the court can decide about his/her transfer to normal prison

By the end of 2009, the youth prison population in the Czech Republic accounts for around 16% of the total prison population. 66 of the prisoners are under 18 years old, 621 prisoners in between 18 and 21 years old and 2.425 prisoners in between 21 and under 25 years old. The total number of prisoners in juvenile prisons is 174, women account for around 5% in the juvenile prison population. As mentioned above, by the age of 19, the court can transfer the prisoners to adult prisons. Therefore the number of those in juvenile prisons may include also prisoners older than 18 years.

In **Estonia**, there are no special detention facilities for young prisoners. Young prisoners are all kept in adult prisons in separate departments.

On the 20th of September 2010 the total number of prisoners in Estonia accounts for 3.433. 44 of these prisoners are minors under 18 years old.[2] About 569 prisoners are between the age of 14-24 (16.6%). About 54% of all young prisoners are Russian speaking Estonian citizens and about 95% percent of young prisoners are male.

In **Germany**, young prisoners are either placed in separate prisons only for young people or in special sections of prisons for adult offenders. By the age of 24 of the

[2] "Prison statistics" [http://www.vangla.ee/41291] 10.08.2010

young prisoner, the youth sentence has to be executed following the principles of adult sentence (§ 89b JGG).

By 31.03.2009, the total prison population in **Germany** accounted for 61.878. On this date, 19,1% (i.e. a total number of 11.807) of the total prison population, were under 25 years old and 10,3% (i.e. 6.344) of the total population were in juvenile sentence. Around 4,2% (i.e. a total number of 500) of the prison population under 25 years old are females, their proportion lies at 3,7% (i.e. 237) of the population in juvenile sentence.

10% of the prisoners under juvenile law fall under the age group of the 14-18 years old, around half of the prisoners (49,4%) fall under the category '18-21 years old' and 41% under the category 'more than 21 years old'.

In **Latvia**, by 1st of January, 2010 the total number of those up to 18 years old in the prison population accounted for 149 which was 2.1 % of the total number of all prisoners (n=7.055). 96 from 149 were imprisoned in correctional institutions for juveniles. The mentioned rate (2.1%) is one of the highest rates in EU.

Sentenced young offenders in **Romania** can either be placed in re-education centres or in special prisons for young offenders.

According to data provided by ANP (August 2010), there are 5.658 young prisoners aged between 14-24 years in Romanian detention units, 5.465 male (96,59%) and 193 female (3,41%). The total prison population is 28.185 prisoners. This means that young prisoners represent 20% of the total prison population.

The majority of prisoners serving their sentence in re-education centres are aged between 14 and 18 years (95.8%). In minors and youth prisons, 72.61% of the young prisoner population is aged between 18 and 21 years. From the total of youth between 14 and 24 years of age serving their sentences in prisons, 68.57% are aged between 21 and 24 years.

Those aged between 21-24 years represent more than half of the total young prisoner population (58.9%). Criminally liable under-aged offenders (aged between 14-18 years) serving custodial sentences represent just 7.9% of the total young prisoners population. This is because most of them are sentenced in the community in re-education centres.

In **England and Wales** custodial sentence for young offenders can take place in secure training centres (STCs) (vulnerable young people up to 17 years old), secure children's homes (SCHs) (accommodating vulnerable young people from 12 to 14 (16) years old), young offender institutions (YOIs) (accommodating 15 to 21 years old).

The prison population (including pre-trial detainees/remand prisoners but excluding juveniles in Secure Training Centres and Local Authority Secure Children's Homes) was 85.009 (30/07/10), the percentage of pre-trial detainees/remand prisoners was 15.3% (30/06/10), the percentage of women prisoners was 5% (30/07/10) and the

percentage of Juveniles / minors / young prisoners (under 18 years) was 2% (30.06.10) in addition to these 1.660 juveniles a further 267 were being held in Secure Training Centres and 169 in Local Authority Secure Children's Homes. In June 2010 foreign prisoners made up 13.1% of the prison population (the nationality of an additional 3.4% was unrecorded).

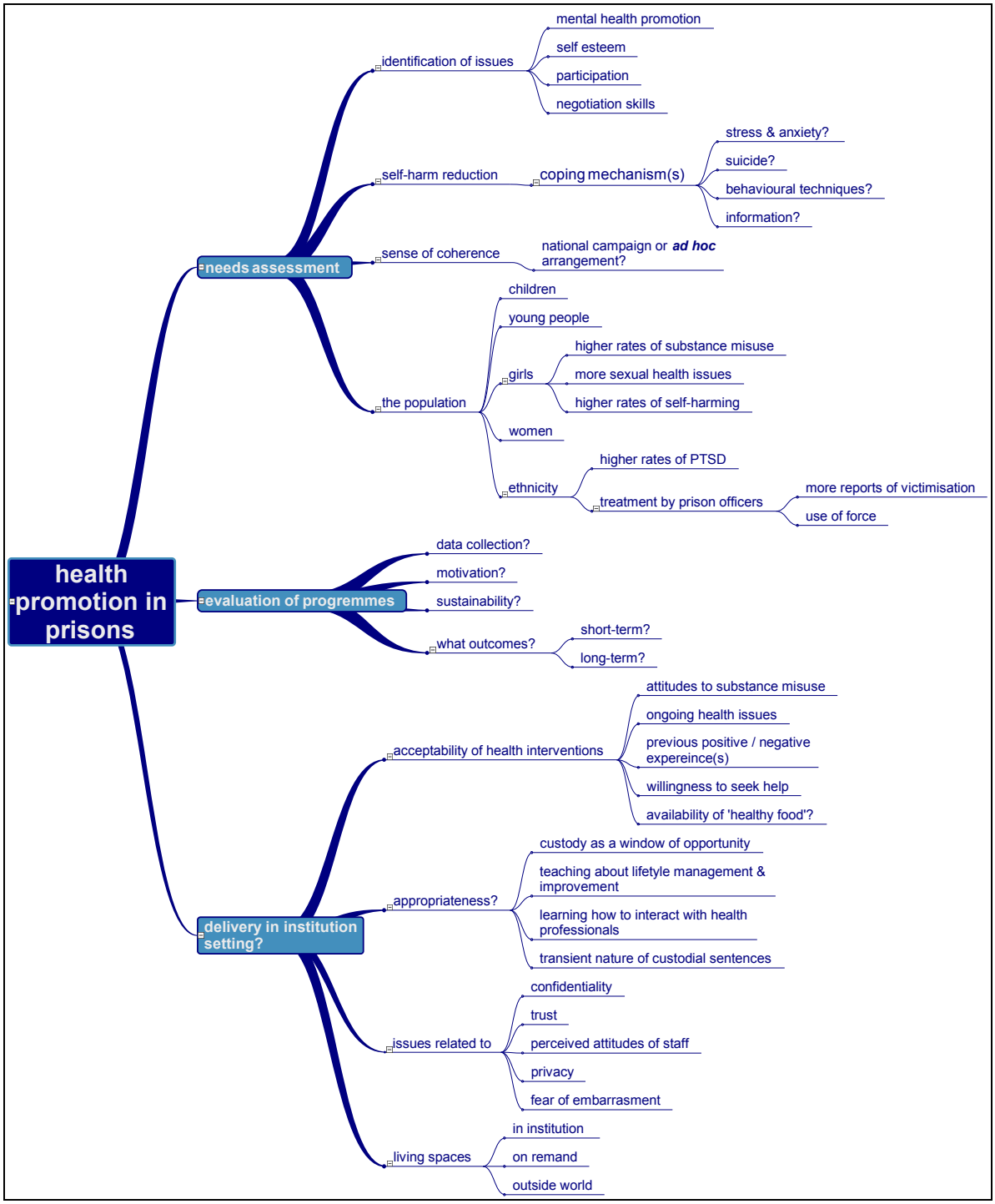
3. The relevance of health promotion for young offenders

Young prisoners return to the community, and therefore it really matters how they are treated in prison. Either we can give them education, target group specific care and support, to make good the ravages of what they have denied themselves by truancy or been denied by exclusion, as well as opportunities for personal development within a structured, caring environment (which we implicitly hold to be the way that can best lead to the development of responsible citizens), or we can continue on the present course, with all the damage that is doing not only to the young people themselves but to our society to which they will return. All but a few young people are eventually released back into their community, so it is essential to consider what happens to the physical and mental health of them while they are incarcerated.

The experience of being in custody could be viewed as a window of opportunity for teaching and learning about lifestyle management and improvement for learning about how to interact effectively with health professionals e.g. to improve general communication(s) skills. Nevertheless, worryingly high reconviction rates demonstrate that, if the regimes and conditions are not needs-based and effective, custody can do more harm than good; young offenders' learning whilst in secure establishment often may criminalise rather than rehabilitate and thus reduce the chance of reoffending.

Figure 1 highlights health promotion issues pertinent to young people in prison settings.

Figure 1: Flowchart health promotion targeting young offenders



4. Problems and challenges in custody in the HPYP partner countries

The information outlined in the following paragraphs is drawn from the national HPYP literature reviews. These literature reviews are based on the available data, information and the respective national body of literature related to the topic health of young offenders in the partner countries. The policies, approaches and the general legal and structural circumstances vary significantly across Europe as well as the availability of information and data. Thus, it is difficult to compare the results of the national literature reviews. However, some overall problems, challenges and conclusions in terms of health promotion became obvious, which are outlined in the following chapters.

4.1. Structural issues

In particular the Baltic States report a strong impact of the economic crisis on the current situation of their prison systems and severe structural problems, which negatively impact on the health of prisoners.

Due to financial crisis the Latvian State Probation Service has reduced its functions and since 2009 they stopped the provision of the post-penitentiary assistance to released prisoners, thus negatively influencing the penitentiary system of the country. The overall financial crisis in Latvia has extremely aggravated all problems in prison system in general and it resulted in a major reduction in the field of Prison Medicine (the prisons system will no longer have earmarked funds for health) and impacts on finance for medical expenditures and hospital service, the possibilities for diagnostics, the number of medical staff and salaries of medical staff. Now medical staff cannot carry out medical activities in accordance with the national legislation. This will lead to significant worsening of prisoners' health care, the morbidity and presumably also on the incidence of infectious diseases. In the case of an epidemic outbreak in Latvia, prisons will become a spreader of these diseases because it will not be possible to carry out all necessary activities. Thus prisons will release people with large scale of health problems that will influence negatively the public health as a whole. Several health related activities are planned to be implemented in prisons within the existing state budget and political willingness of the government is obvious, however due to the financial crisis and the budget cut-back it is not likely that they will be implemented.

Also the Bulgarian prison system has severe structural problems. The buildings of Bulgarian prisons are very old and run down. The Sofia prison was built 100 years ago. The main buildings of the prisons in Lovech, Pazardzhik, Vratsa, Stara Zagora, Varna and Burgas were built in the 1920s and 1930s, while the main buildings of the Bobovdol and Pleven prisons are former hostels converted to prisons. Inmates, not only in the hostel buildings, but in all prisons, are accommodated in common rooms in contravention of UN Standard Minimum Rules for the Treatment of Prisoners, which require individual accommodation to be the rule. At present there are no plans for

conversion to smaller cells or individual accommodation, even in parts of the prisons. The capacity of closed establishments has not increased in the last few years. Despite this, more and more prisoners are accommodated in them and as a result the overcrowding in most closed prisons has reached three times their capacity. This contravenes the recommendations of the European Committee for the Prevention of Torture for a minimum of 4 m^2 floor area to be provided to each inmate. The everyday life problems arising from this are connected to the inevitable use of three-storey beds in sleeping quarters and the use of common rooms for sleeping, including clubs and sports facilities.

The Bulgarian legislation has no compulsory standards for living conditions and living area in prison quarters. According to the European Prison Rules, every inmate has to be provided with enough fresh air, daylight, heating, access to sanitary facilities and drinking water, bathing, medical care and opportunities for education, sports, labour and other activities. The available material resources in Bulgarian prisons are insufficient for most of these recommendations to be implemented. A fundamental problem in the penitentiary system in Bulgaria is the lack of space. The most crowded cells are those in the prisons for recidivists in Plovdiv, Sofia, Varna, Burgas and Pleven, as well as in two of the closed hostels: “Atlant” in Troyan and “Kremikovtzi” near Sofia. In the “Atlant” hostel about 30 inmates live together in 55 m^2 cells, which means that each inmate has 1.7 m^2 of floor area. Also the sanitary conditions are difficult.

The Czech prison system suffers from an on-going increase of the prison population resulting in overcrowding of the prisons. In the Czech Republic there has been a continual increase in the prison population since 1992 from about 13,900 to almost 21,900 in 2010. The current prison population rate (per 100.000 of national population) is 208. Thus the main problem of the prisons in the Czech Republic is permanent overcrowding. The prison system also faces additional problems in the field of health care (e.g. lack of physicians, complaints about medical malpractice etc.).

The main persistent problem of the Romanian prison medical system is the high deficit of medical staff in almost all detention units. Doctor positions are vacant in Brăila and Târgu-Jiu prisons (nurses positions are occupied and doctors from other units cover the medical services), there is no neurologist in Jilava prison hospital, post-surgical intensive care is provided with difficulty in Rahova prison-hospital because of staff shortage and in some cases dentists provide services in 2-3 detention units. However, medical staff shortages are a general problem in Romania, affecting the medical system as a whole and not only the prison system. Further structural problems of the prison medical system in Romania are insufficient funds for the proper equipment of medical facilities; lack of continuous training programmes for medical staff; insufficient supply of medication for the treatment of prisoners.

4.2. Conditions in pre-trial custody

Most of the reviews report that the general conditions in pre-trail custody are worse than those in facilities for convicted prisoners. In particular in the Czech Republic pre-trial custody is frequently carried out under difficult conditions (Motejl, 2010). The number of specialized staff in pre-trial custody prisons (psychologist, social worker, educator, spare time instructor) is insufficient. For example psychologist in some pre-trial custody settings are responsible for more than 200 prisoners or even more. There are almost no civil employees in pre-trial custodies and security staff members have to take over among other things educational responsibilities. The report states that prison staff does not even know for how many and which prisoners he or she is responsible for. It was pointed out that electric lightening is not adequate and barriers on the windows (prevention of handing things over through the windows) complicate the situation even more. In practise there is a rule which says that only prisoners from the same cell are allowed to speak to each other. Prohibition of communication between prisoners from different cells could obstruct more efficient ways of using the staff´s capacities. There is a lack of space which stems from an overpopulation. This situation is caused by the lack of financial resources as well as unsuitable architectonic and technical condition of the prison buildings.

4.3. Minority groups/migrant prison population

In the Czech Republic minority groups are not reported in statistical system of the prison administration; nevertheless the most common group is Romani people. Romani tend to have problems at school (school performance and disciplinary problems) earlier than the majority of children. They are more often and earlier placed in special schools than compared to the majority. Furthermore, they are at higher risk to experience social exclusion and manifestation of pathological developments, in particular if use of addictive substances among children and adolescents is fully manifested.

In Bulgaria, about 40% of the prisoners (in 10 out of 12 prisons) determine themself as Romani. Severe social problems, marginalisation and drug abuse are highly prevalent in this minority group.

In Germany, migrant groups are also overrepresented in prisons (about one quarter of the total prison population), however statistical data is difficult to interpret. A large group of young prisoner with migration experience have Russian roots and drug and alcohol use are frequent problems in this group.

In Latvia, migrant prisoners are not yet identified as a specific problematic group. Although there is a tendency observed that the number of foreign prisoners is slightly increasing.

In England and Wales, according to Ministry of Justice (2009) figures, there are currently four times more arrests of Black people per head of population than of White

people, and there are five times more Black people in prison per head of population than White people. Table 4 shows the proportion of young people aged 10 to 18 from different ethnic groups in the different stages of the criminal justice system. When there is a higher proportion of an ethnic group compared to the general population then there is 'disproportionality and they are over-represented at that stage in the criminal justice process' (MOJ, 2009). Much of this is linked to disadvantage. In one recent research project, Hill (2007) links law-breaking behaviour of a sample of young black people to the structures of inequality within which they live their lives

Similar data exists about over representation of black people in mental health services which raises important questions about inequality, and the links between mental ill health and offending or sentencing.

Table 3: Percentage of ethnic groups at different stages of the criminal justice process compared to the ethnic breakdown of the general population, England and Wales 2007/08 (source: MoJ, 2009)

	Ethnicity						
	White	Mixed	Black	Asian	Chinese or Other	Not stated/ Unknown	Total
General population (aged 10 & over) @ 2001 Census	91.3	1.3	2.2	4.4	0.9	0.0	100
Stops and searches[1]	68.1	2.5	13.1	8.1	1.2	7.0	100
Arrests[2]	79.3	2.8	7.4	5.1	1.4	4.0	100
Cautions[2][3]	82.5		6.5	4.6	1.4	5.0	100
Youth offences	84.8	3.5	5.8	3.0	0.4	2.5	100
Tried at Crown Court[3][4]	73.5		14.0	8.0	4.4	*	100
Court ordered supervision by probation service[5]	83.6	2.5	6.3	4.6	1.2	1.8	100
Prison receptions[6]	79.1	2.9	10.6	5.9	1.2	0.2	100

Note: Figures may not add to 100% due to rounding.

(1) Stops and searches recorded by the police under section 1 of the Police and Criminal Evidence Act 1984 and other legislation

(2) Notifiable offences

(3) The data in these rows is based on ethnic appearance, and as such does not include the category Mixed ethnicity (the data in the rest of the table is based on self-identified ethnicity)

(4). Information on ethnicity is missing in 19% of cases; therefore, percentages are based on known ethnicity

(5) Commencements

(6) Sentenced

The Ministry of Justice Report (2009) indicated that there are clear imbalances in the way people from ethnic minority backgrounds experience UK criminal justice system. In particular, the findings show that there were almost four times more arrests made of Black people than of White, whereas there was significantly less use of cautions (16%) for Black offenders than of White (24%). A greater proportion of White defendants (78%) were found guilty than Black (75%) or Asian (73%) defendants. However, custodial sentences were given to a greater proportion of lack ffenders (67%) and those in the Other category (68%) than White (53%) or Asian offenders (57%).

The balance of ethnicity amongst young offenders follows a similar pattern. The vast majority (85%) of cases involving young offenders in 2997 were White whereas 6% were recorded as Black, 3% as Asian, 4% as Mixed ethnicity and less than 1% as Chinese or other ethnicity. Offences committed by Black young offenders were more likely to receive a custodial sentence when compared to offences committed by the other ethnic groups.

The youth justice system in the UK has long been characterised by the over-representation of black and minority ethnic young people. Children classified as black or black British are less likely to receive a pre-court disposal, more likely to be remanded to custody or secure accommodation, and disproportionately represented among those receiving a custodial sentence. During 2007/08, for instance, while black or black British young people made up 3% of the general 10 – 17 population, they accounted for 7% of those coming to the attention of the youth justice system, 14% of those receiving a custodial sentence and almost one in three of those given a sentence of long term detention (Youth Justice Board, 2009).

4.4. Health related problems in prisons

In general the literature reviews revealed that in neither of the partner countries systematic assessments of health related needs of young prisoners have been carried out so far. The data and information available from the partner countries differs significantly and some of the information is not specific for young prisoners and refers to the prison population in general.

4.4.1. Mental health and substance use

National literature reviews pointed out that the mental health status of the prison population and lack of treatment opportunities is one of the most relevant health related issues in European prison systems.

The Bulgarian report states that the existing activities and services do not sufficiently cover the needs of prisoners related to the consequences of isolation and rationalization of their stay in prison. Treatment and care for prisoners with mental health problems is mainly medical oriented and there is a strong need for the development of an overall conception for their treatment in the conditions of a closed environment. The main factors having a negative effect on the mental health of prisoners are the following:

- Poor living conditions and overcrowding**:** In Bulgarian prisons this is one of the serious problems, as it was pointed out in the reports of various human rights protection organizations and of the Committee or the Prevention of Torture and inhuman or degrading treatment and punishment (CPT).

- Forced communication and conflicts: In the prison settings forced communication usually have serious negative effect on the mental health of the inmates.
- The isolation from relatives and outside world: It is obvious that the biggest problems exist with the group of prisoners from the closed type of institutions. These are high security prisons with a high level of isolation. The access to them is fixed in the legal normative regulations. In the Bulgarian prisons of closed types there is only one kind of visit: through a screen and telephone. In the prison of open and transitional type, the contacts are held directly.
- The lack of effective treatment for prisoners with mental health problems: Usually prisoners with mental problems are accommodate together with those without specific mental health issues. This practice has certain positive effects with respect to prisoners with mental problems, since they are not isolated additionally. Actually, the serious problem is the lack of specialized and effective treatment and care approaches for prisoners with mental disorders. The lack of training for prison staff also leads to conflicts, derangements, insults and additional tension in the prison setting. A serious problem is also that the staff is not trained enough to work with prisoners who are drug dependent or have serious mental and emotional problems.

Self-harms and injures are highly prevalent in Bulgarian prisons. The staff has not been specially trained to identify the symptoms and to react adequately and thus has to rely on their previous experience and intuition. In case of conflicts the prisoners with mental problems are often participants, victims and objects of disciplinary measures. The existence of these problems is due to a great extent to the fact that there are no integrated activities to inform prisoners how to behave to inmates having problems with their mental health. The lack of specific programmes for care and support of mentally ill prisoners very often is the main reason for self-harms and suicide attempts among this vulnerable group of prisoners. The number of suicides among young prisoners is higher than the other prison population: There are 3-4 suicides per year and about 50 suicides attempts among young prisoners.

In Germany there no comprehensive documentation on the health of young prisoners is available. However, single studies mainly focus on mental health and drug use. Prevalence rates of mental health problems, alcohol and substance use are very high among young prisoners. Köhler et al. (2010) examined the mental health and personality of 149 juvenile inmates. According to the study, prevalence rates of mental health problems are alarmingly high. Around 81% of the prisoners had some kind of conduct disorder, further prevalent diagnoses were personality disorders (up to 60%), and psychopathic features were found in 21% of the participants. According to this study, mental health characteristics in the juvenile prison population are comparable to populations in paediatric and adolescent psychiatry. Substance use disorders in young

prisoners according to the study are especially high for alcohol (with 60% showing alcohol abuse and 20% alcohol dependence), amphetamines (with 40% showing amphetamine abuse and 10% dependence) followed by hallucinogens (38,3% showing abuse and 22% dependence). Dependence rates are in particular high for cannabis (54%). Treatment of prisoners with mental health problems in prison is described as inadequate mainly due to a lack of resources and the fact that alternatives to prison are often not applied (Lehmann, 2009). Health promotion for young prisoners in Germany is often reduced to prevent infections with hepatitis and HIV. Other aspects such as smoking, alcohol, sports and exercising, sexuality and violence are often not included into the concept (Enzmann & Wiessner, 2004).

The Estonian report describes prisons as settings which are characterized by multiple health burdens: high spread of blood borne viruses (HIV, HBV/HCV), other infectious diseases (TB, STIs), co-infections, drug addiction, and mental diseases. There is no specific epidemiological data mentioned, but stated that a substantial number of prisoners are suffering from either of these health damages or more than one.

Also in the United Kingdom one of the biggest issues facing offender management is the prevalence of mental health issues amongst offenders (Keil et al., 2008). However, much of the work already done on mental health in prison has concluded that, despite the introduction of mental health in-reach teams, prison mental health care was under-resourced, still failing to meet the needs of prisoners with complex mental health needs (such as dual diagnosis and personality disorder), and, in fact, often not meeting the needs of seriously mentally ill people as was originally envisaged (Steel et al, 2007). Much of the work has also questioned the appropriateness of prison for those with mental illness whose crimes were less serious and not ‘goal-directed’.

One of the most anticipated reports was *The Bradley Report: Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system* (Bradley, 2009). This report highlighted the needs of the growing proportion of prisoners with mental health issues in prisons and observed that there had been increasing recognition amongst policy makers that equivalence of care is required. Bradley observed that there was a growing consensus that prison was the wrong environment for prisoners with mental health issues because custody could ‘exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide’ (Bradley, 2009: 7).

The Bradley Report (2009) makes three key recommendations for children and young people in the area of mental health and vulnerability that:

- awareness training in mental health and learning disability be provided, so that all staff in schools and primary healthcare, including GPs, can identify those who need help and refer them to specialist services;
- all youth offending teams (YOTs) should have a suitably qualified mental health worker who has the responsibility for making appropriate referrals to other services;
- the potential for early intervention and diversion for those children and young people with mental health problems or learning disabilities who have offended or are at risk of offending should be considered.

4.4.2. Infectious diseases

The penitentiary systems in particular the Baltic countries and Bulgaria suffer from high prevalence rates of infectious diseases. In Bulgaria about 1% of young prisoners are infected with HIV.

Also in Latvian prisons HIV and other infections (TB, STIs, HBV and HCV) are significant problems. There are about 7.000 people in 12 prisons. 1.155 cases or 25% of all newly diagnosed HIV cases (N=4.614) are being reported from prisons by December 31, 2009. This rate may be due to the large scale testing being performed for this population. All prisoners entering the prison system pass a medical examination including an HIV test (except if they explicitly refuse) within the first three days after arrest. In recent years approximately one fifth from all annually diagnosed HIV cases in the country are diagnosed in prisons. However, it is still unclear whether the HIV infection had been contracted before or during detention as the testing is provided only at entry to prisons and not before release. The HIV prevalence rate among all prisoners is about 6.6% (compared to 0.2% in the general population).

Estonian prisons are described as settings which have to cope with high prevalences of infectious diseases: high spread of blood borne viruses (HIV, HBV/HCV), other infectious diseases (TB, STIs), co-infections and drug addiction. There is no specific epidemiological data mentioned, but stated that a substantial number of prisoners are suffering from either of these health damages or more than one.

In Romania, drug use in prisons is also common among youth. In 2008, according to the National Anti-drug Agency, about 29% of the prisoners declaring to have a drug use history were aged up to 24 years. According to the 2009 HIV, HBV and HCV Behavioral Surveillance Survey among injecting drug users in Bucharest implemented under the coordination of the United Nations Office on Drugs and Crime (UNODC), 56% of the IDUs (aged between 18-24 years, ex-prisoners and with a drug use history) declared they injected while in prison. According to the 2009 HIV, HBV and HCV Behavioral Surveillance Survey among prisoners in Romania implemented under the coordination of the Romanian Angel Appeal Foundation (RAA), data on the age group

18-24 years shows that 9% used cocaine; 6% injected with substances; 4% had access to free of charge sterile needles/syringes; 49% got tattooed in prison; 22% used condom during their last intercourse; 47% had free access to condoms; 53% attended sessions on HIV/AIDS; 33% were tested for HIV in their lifetime.

4.4.3. Policy related issues

In Estonia, Latvia and Bulgaria there are no national policies or action plans that are targeting health promotion for juvenile or young prisoners. In Germany due to the federal system, health promotion initiatives differ significantly across the country and depend on the respective policy of the Länder.

Latvia has no specific state funds allocated for the health promotion and prevention activities in prisons (inter alia among young prisoners). Such activities are held in prisons fragmentary, mostly based on concrete projects and are carried out by NGOs. One of the broadest projects in Latvia in the field of prevention activities among prisoners already since 2006 is financed and implemented by UNODC. The overall goal of the project is to assist Latvia to halt and reverse the HIV/AIDS epidemics among injecting drug users and in prison settings.

5. Characteristics of young people who offend

Age, gender and ethnicity are factors that impact on young people's involvement with the criminal justice system.

About a large proportion of all young prisoners are homeless or have been in insecure accommodation before they are incarcerated. The share of young offenders who have experienced care is higher than the general population of equivalent age. Few possess transferable skills having consistently truanted or left school early; many may have had damaging personal and emotional experiences so there is poor general understanding of concepts related to individual responsibility, adulthood, health and well-being. Often the young people are physically unfit with low self-esteem and many have been physically or sexually abused. They are usually deeply embedded in 'street culture' and are disconnected from the rest of the population.

The UK literature review informs that children and young people in the Youth Justice system are likely to have experienced domestic violence, neglect, physical and sexual abuse within their family with one study reporting that this group are at least twice as likely to have experienced serious child mistreatment than the population as a whole (Prison Reform Trust, 2008). Serious child mistreatment are risk factors that impact on the development of both mental health problems and the risk of offending. Those

young people who are housed in the secure estate are particularly at risk from bullying, self-harm and suicide and require careful monitoring and assessment to ensure their mental and physical well-being. Key information and figures about the number of children and young people who are at risk of coming into contact with the youth justice system are provided by the *Healthy Children, Safer Communities* (2008:14) *strategy* document:

- *138,692 children and young people in England committed an offence in 2007/08 that resulted in a reprimand, final warning or court disposal (Youth Justice Board, 2009);*

- *3000 children and young people are in young offender institution, secure training centre, secure children's home at any one time. (YJB, 2009);*

- *The majority of offences committed by young people (79 per cent) are committed by boys, but the number of offences committed by girls has risen.*

- *The health and well-being needs of children and young people tend to be particularly severe by the time they are at risk of receiving a community sentence, and even more so when they receive a custodial sentence;*

- *Over three quarters of children and young people in the YJS:*

  - have a history of or permanent school exclusion (Parke, 2009)
  - have serious difficulties with literacy and numeracy (Social Exclusion Unit, 1999)

- Over *half* of children and young people in the YJS:

  - have difficulties with speech, language and communication (Bryan, 2004)
  - have problems with peer and family relationships (Harrington and Bailey, et al ,2005)
  - who commit an offence have been a victim of crime – twice the rate for non-offenders (Roe and Ashe, 2008)

- Over a third of children and young people in the Youth Justice System:

  - have a diagnosed mental health disorder (Hagell, 2002)
  - accessing substance misuse services are from the YJS (National Treatment Agency, 2009)
  - have been looked after by the state (YJB ,2007)
  - have experienced homelessness (YJB ,2007)

- Over a quarter of children and young people in the Youth Justice System:

  - of young men in custody (and a third of young women) report a long-standing physical complaint (Lader et al 2000)
  - have a learning disability (Harrington et al 2005)

- A high proportion of children and young people in the Youth Justice System:
  - of children from black and minority ethnic (BME) groups, compared with others, have post-traumatic stress disorder (Harrington et al 2005)
  - have experienced bereavement and loss through death and family breakdown (Childhood Bereavement Network, 2008)

Table 4: The problems experienced by Young People when they arrived in custody (Source: HMI Inspectorate, 2010)

When you first arrived, did you have problems with any of the following?	Overall young men	Overall young women	Overall young people
Not being able to smoke?	48%	72%	48%
Loss of property?	10%	13%	11%
Housing problems?	12%	19%	12%
Needing protection from other young people?	5%	2%	5%
Letting family know where you are?	21%	37%	21%
Money worries?	15%	9%	15%
Feeling low/ upset/ needing someone to talk to?	19%	37%	20%
Health problems?	11%	15%	11%
Getting phone numbers?	25%	45%	26%

6. Examples of good practice from the HPYP partner countries

For the partner countries it can be summarised that there are only few health promotions programmes and national strategies specifically targeting young people in the prison setting. Only in the UK, there already exists a wide range of health promotion practice. Literature reviews highlighted that there is a range of initiatives taking place which target different health promotion issues related to young offenders around the EU, however most of them are on an ad hoc basis that depends on staff´s and educationalists' goodwill, areas of interest and expertise and approaches towards inmate rehabilitation. Little appears to have been published concerning short- or long-term effectiveness of such interventions. Overall, a lack of integrated approaches on health promotion for young prisoners became obvious. The sustainability of many of these health promotion programmes and activities is problematic. Initiatives often could not be continued due to a lack of funding.

Furthermore, reviewing the literature has clearly identified that not many health promotion initiatives have been evaluated; little appears to be known about what works and for whom. However, adopting an integrated approach to health promotion that includes a social marketing approach has the potential to strengthen the impact and effectiveness of interventions that promote health and wellbeing.

The literature reviews highlighted a few initiatives, which are described below.

The Czech pilot programme "Stop, Have a Think, Change yourself" addresses coping behaviour related to the criminal activities hanging and social behaviour in general (social skills training). It motivates prisoners to change not only their attitudes, but also their behaviours. The programme is based on cognitive-behavioural psychotherapy and is designated for the general prison population, in particular for convicted prisoners who expect a potential petition of grace. It is a three months group session. Depending on the evaluation, the prison service of the Czech Republic will decide whether to fully integrate this programme into the standard treatment programme. Furthermore, in the Czech Republic short courses on conflict solving are offered. The target group of this programme are convicted women who easily get in trouble with other convicted women or are easily influenced by them. It has been applied so far only to a very limited number of female prisoners.

Due to general increase of violence among sentenced boys, the Czech Prison Administration developed a treatment programme for violent juveniles (Programme TP 21 JUNIOR). This programme 3 month programme is currently tested in the Všehrdy prison. Target group of this programme are juveniles with behavioural disorders, violent, aggressive and/or bullying behaviours. Large numbers of these juveniles have problems related to drug addiction, personality and behaviour disorders.

The Bulgarian pilot program “Individual approach towards young prisoners” has been delivered in 2004. It included the implementation of group therapy and psychological support for young offenders. Some of the activities and services delivered are anger management, coping with aggression, problems solving, psychological support and working with young sex offenders. The duration of the program was 10 months and after completing the programme, the guideline “Group programmes for young prisoners” has been published.

For several years in all Estonian prisons psychological support groups for people living with HIV and drug using inmates are provided by NGO Convictus Estonia. The goal of Convictus is to offer psychosocial support and consultations for HIV-positive and drug users in Estonian prisons with the general aim to stop the progressive spread of HIV/AIDS and provide high quality treatment and access to health care and social services for HIV-infected persons and problematic drug user. Convictus works with young and juvenile prisoners in both Viru prison (boys and young men) and Harku prison (girls and young women). The activities of Convictus are financed by the Ministry of Justice.

One of the broadest projects in Latvia in the field of prevention activities among prisoners already since 2006 is financed and implemented by UNODC. It was a four year project called “HIV/AIDS prevention and care among injecting drug users and prison settings in Estonia, Latvia and Lithuania”. The overall goal of the project was to assist Estonia, Latvia and Lithuania to halt and reverse the HIV/AIDS epidemics among injecting drug users and in prison settings. The services implemented by NGOs mostly focused on providing information through lectures and seminars and distribution of information materials. None of the projects provided either syringes or condoms.

In Romania in the period 2008-2009, the project “Developing community support for prisoners’ mental health” was organized with PHARE financing and in cooperation with the National Administration of Penitentiaries. The project aimed at elaborating a set of case management procedures in the field of mental health within prisons, stimulating the mobility of local community resources where prisons exist and providing relevant information to prisoners, prison staff and specialists from the community. A number of information materials were produced and disseminated and a series of specific psychosocial assistance programmes were developed for prisoners with mental problems, prisoners with aggressive behaviours, those at risk for suicide and prisoners with sexual offences. However, all programmes are not specifically aiming at young prisoners, but at the prison population in general.

A key strategy for young offenders in the UK is the *Healthy Children, Safer Communities (2008)* which is cross governmental with the key aim to improve the health and well-being of children and young people at risk of offending and re-offending. This is a discrete strategy focusing on young people in recognition of their complex and emerging health needs that are very different to those of adults. The strategy is a joint document led by the Department of health with the Department for Children, Schools and Families, the Home Office and the Ministry of Justice. Three key sources inform the strategy:

- It builds on the *Youth Crime Action Plan*29 and on the agenda set out in *Healthy Lives, Brighter Futures* for improving the health outcomes of *all* children and young people, including the most vulnerable.
- It responds to the Healthcare Commission and HMI Probation’s findings on the inadequate provision for those in contact with the YJS.
- It reflects the vision set out in the *Children’s Plan*31 and the *Every Child Matters* Programme, that improving outcomes is something to champion for all young people. Together, these initiatives make a compelling case for effective health and welfare interventions in tackling youth crime (HM Government, 2009:6)

One section in the strategy that is particularly relevant to the HPYP project is *Addressing health and well-being throughout the youth justice system.* This section has 5 key objectives:

- to ensure that more children are diverted from the YJS;
- to improve provision of primary and specialist healthcare services to young offenders;
- to ensure that courts and sentencers receive accurate information about health and wellbeing needs and the services to meet them;
- to promote health and well-being in the secure estate;
- to achieve continuity of care when children complete a sentence. (HM Government, 2009:7)

7. The way forward

Prison Services in the EU Member States have the responsibility to ensure that prisoners and in particular young prisoners have access to health services that are broadly equivalent to those the general public receive and that meet their specific needs as one of the most vulnerable groups in society. This means that prisons should also provide health education, patient education, prevention and other interventions that promote wellness:

- Build the physical, mental and social wellbeing of prisoners (and where appropriate staff) as part of a whole prison approach
- Help prevent the deterioration of prisoners' health during or because of custody, especially by building on the concept of decency in the establishments
- Help prisoners adopt healthy behaviours that can be taken back into their community upon release.

Health promotion should be offered within a whole prison approach. This involves an approach which draws upon resources from across the prison and encompasses all aspects of prison life which impact on the wider determinants of health (such as education and life skills), while at the same time addresses prisoners' health needs through health promotion, health education, patient education and prevention. In order for this approach to be delivered and implemented, prisons should have a health promotion action group that includes key community health providers. It should become a prison performance indicator requirement that prisons have health promotion action groups with appropriate stakeholder membership to the local health community.

It is important that health education plays a major role in the provision of care for young prisoners and that health care plans for young prisoners are based on clear understanding of their real needs that reflect the range of requirements across different ethnic groups. In order to understand what the needs are for this population it is

necessary to carry out needs analysis upon which rational planning of required services can be undertaken.

The WHO Consensus statement "Promoting the Health of Young People in Custody" also underlines the need for closer collaboration between prison/custodial services and community services as well as the need for participatory approaches to health promotion: [The Consensus Statement] "*recognises the importance of collaboration between those staff and custodial services and the many other agencies which share the goal of helping these largely vulnerable, disengaged and socially excluded young people in countries throughout Europe. Indeed co-operation must cross the physical boundaries created in custodial settings, and prison health and social care staff should, with consent, have access to the previous health and social care records of young people in custody. Only by agencies and staff working together, and listening to and involving the young themselves, might the following objectives of the Statement be met:*

1. *To promote the physical, mental and social aspects of the health of young people in custody;*
2. *To help prevent the deterioration of young people's health during or because of custody;*
3. *To help young people in custody develop the knowledge, skills and confidence they need to enable them to adopt healthier behaviours that they can take back into the community with them.*"

8. Implications for the development of the HPYP toolkit

The recommendations from the evaluation of the UK programme *Every Child Matters* toolkit are particularly important for the HPYP project as the design and content of the HPYP toolkit can benefit from the learning generated by the findings. The following key recommendations from the evaluation that are appropriate to the potential HPYP toolkit were made:

- The toolkit should be available in word or excel so that data can be complemented when the toolkit is used.
- Resources that are provided should be age appropriate rather than universal to be used with all young people.
- The toolkit needs to be well publicised to raise awareness and increase the implementation in as many settings as possible.

In addition, the toolkit for young offenders should achieve effective, measurable outcomes which

- have foundations in behaviour and skills training and relate lessons learned to real life
- have consistent aims and methods
- are carefully matched to the individual offender's needs
- are designed to help individuals into employment or school, preferably in their own local area.

Consultation for development of this toolkit should represent a wide variety of professional stakeholders. Prison service, social workers, PCTs, Probation Service, Governors, Trade Unions, educationalists, public health specialists, and prisoners must also be involved in this process.

Finally reviewing the literature in the HPYP partner countries has clearly identified that not many health promotion initiatives have been evaluated; little appears to be known about what works and for whom. However, adopting an integrated approach to health promotion that includes a social marketing approach has the potential to strengthen the impact and effectiveness of interventions that promote health and wellbeing (National Social Marketing Centre, 2006; Griffiths et al., 2009). This principle could be applied to the development of innovative health promotion approaches and toolkits. In addition in its development an appropriate evaluation programme should be designed in accordance with the following health promotion principles: empowering, participatory, holistic, intersectoral, equitable, sustainable, and multi-strategy (Springett, 2001).

Community asset mapping (Kretzman and McKnight, 1993; Royal Society for Public Health, 2010) is another approach that identifies structures and resources within communities and organisations and the method is adaptable for a range of conditions and situations. Sometimes asset mapping turns conventional thinking on its head because instead of a needs-based approach - which often tends to concentrate on negative aspects – this strategy is designed to explore the assets a community possesses rather than those it does not. Asset mapping then sets participants the task of developing solutions based on their findings.[3]

The asset mapping approach allows young offenders and those who have been recently released to find a voice; it therefore appears to offer possibilities for engaging in health promotion with this group of young people who may be lacking in self-esteem, lacking in awareness of issues relating to personal responsibility for health and wellbeing and thus could encourage them to help to devise solutions that facilitate change.

[3] An outline of this approach is available from: http://www.northwestern.edu/ipr/publications/community/introd-building.html

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