Throughcare
Working in partnership

Directorate-General Justice,
Freedom and Security

# LITERATURE REVIEW: ESTONIA

## THROUGHCARE

## WORKING IN PARTNERSHIP

**Tallinn 2009**

## 1.0 Drug use among the general population in Estonia

The 2006 health behaviour survey published in 2007 contains data on the use of cannabis, but not on overall drug use. The survey indicated that 10% of men and 5% of women had used cannabis once or twice in their lifetime, 3.6% and 2.3% respectively during the previous 12 months. The survey found that 3.4% of men and 0.4% of women had used cannabis more than 40 times in their lifetime. According to the survey results, 49.8% of men and 71% of women aged 16-24 claimed that they had never tried cannabis. Other background data indicates that a person who has used cannabis during the previous 12 months is likely to be single, educated to primary or basic level, unemployed and has no health insurance. It seems that neither nationality nor place of residence play a role in cannabis use (EMCDDA, 2008).

### 1.1 Drug use amongst specific groups

The ESPAD survey of 15-16-year old school students indicates that drug use among students has increased since the 1990s. In 2007, 33% of students, 62% of boys and 38% of girls had tried a narcotic substance compared with 7% in 1995, 15% in 1999 and 24% in 2003. Results of the surveys conducted over the years suggest that the most popular narcotic substances among school-aged students are cannabis, inhalants and tranquilizers/ sedatives. In 1995 the number of students who had tried amphetamines at least once in their lifetime increased dramatically, but in 2007 'poppers' were a newcomer. According to the survey, the average age for students to try illegal narcotic substances for the first time is 13–15, but 24% of inhalant users and 19% sedative users had started before the age of 11 (Allaste et al.2008).

A pilot survey on the prevalence of HIV and sexually transmitted diseases and risk behavior among men who have sex with men (MSM) (n=59) was conducted in Tallinn and Harju County in 2007. The sample was formed by employing a respondent-driven sampling method. 1.5% of the sample had used narcotics in other ways than injecting during the last 30 days. None of the studied MSMs had injected drugs during the last four weeks and six months (Uusküla et al., 2007).[1]

### 1.2 Problem drug use

There is no up-to-date estimate for problem drug use in Estonia. However, in 2004, the prevalence of IDU was estimated at 15 cases per 1,000 inhabitants aged 15–44. This was exceptionally high compared with the average across the EU. Earlier surveys indicate that injecting drug users in Estonia primarily choose amphetamine and Fentanyl. Cross-sectional surveys conducted in 2007 among injecting drug users in two regions (Tallinn (N=350) and Kohtla-Järve (N=350)3 suggest a similar trend. As their primary drug, two-thirds of injecting drug users in Tallinn used fentanyl, one-third amphetamine, 0.6% heroin and 0.3% Sudafed. About half (49%) of the drug users sampled in Tallinn and 40% in Kohtla-Järve injected drugs daily.[2]

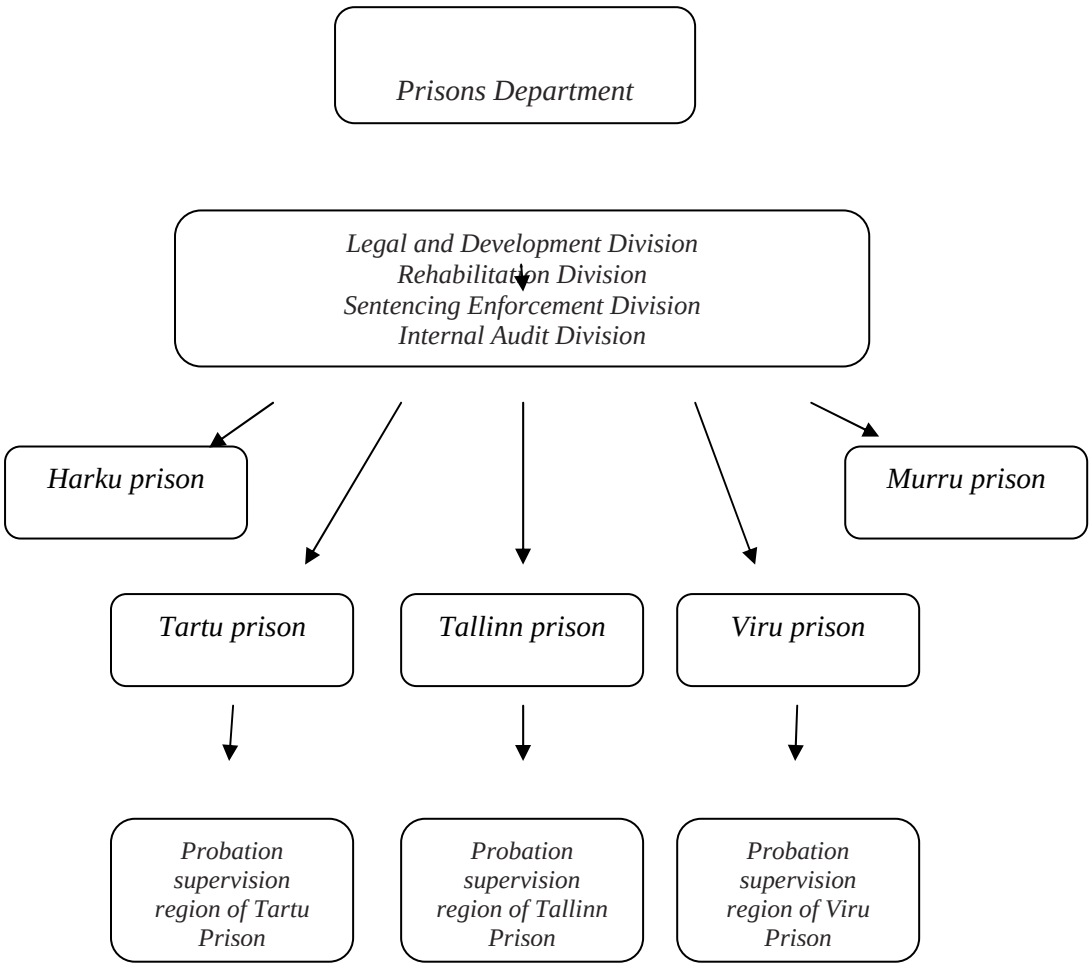
[1] Uusküla, A., Rajaleid, K., Talu, A., Abel, K., Rüütel, K., & Hay, G. (2007a). Estimating injection drug use prevalence using state wide administrative data sources: Estonia, 2004. Addiction Res Theor, 15(4), 411–424.
[2] Trummal, A., Johnson, L.G., Lõhmus, L. (2007). Prevalence of HIV and risk behaviour among men who have sex with men in Tallinn and Harjumaa: pilot survey using respondent driven sampling. Tallinn: TAI.
[http://eusk.tai.ee/failid/report_2008_english_ESTONIAN.pdf ] 08.05.2009

## Prison system

### *1.2.1 Prisons*

In 1993 the responsibility of the penitentiary system was transferred from the Minister of Interior to the Minister of Justice. On December-1 2000 the new Imprisonment Act entered into force. A lot of important changes were stipulated. From 1st January 2000, the Prison Board became part of the Department of Prisons and the management and control of the prisons became directly subject to the Ministry of Justice. The Department of Prisons is an administrative unit of the prison system whose duty is the management of the work of prisons. The department is led by the Justice Ministry's Deputy Secretary-General on Prisons and is divided into four divisions (Scheme 1). Currently, there are five prisons in Estonia: Tallinn, Tartu, Murru, Viru and Harku[3].

**Scheme 1**




In January 2009 the Estonian prison population was 3676. Substantial changes in the number of prisoners have taken place over the last few years; in 2005 there were 4,463 prisoners, whereas in January 2008 this number had dropped to 3,490 (Stover, 2008). Since independence the number of prisoners in the Estonian prison system has considerably exceeded the European Union average.

[3] Estonian Prison System and Probation Supervision Yearbook (2007) [http://www.vangla.ee/orb.aw/class=file/action=preview/id=36156/Estonian+Prison+System+and+Probation+Supervision+Yearbook+2007.pdf] 12.06.09

Such a high prison population is a legacy of the Soviet occupation, in particular, the decomposition of village society combined with a repressive penal system. At independence, there were 4,800 prisoners in Estonia. By 2007, the number of prisoners had decreased considerably to 3,467, reaching the lowest level since 1994. The number of prisoners had declined because there was an increase in the numbers released on parole and a more general decline in the number of offenders entering the prison system (Drew et al., 2008).

A study on HIV/AIDS and drug related knowledge, attitude and behaviour among prisoners, which took place in 2006, gathered data on 807 prisoners (26% of the total number of prisoners). This study found that 50% of the prison population was ethnically Russian. Almost half (44.6%) were Estonians while 5.4% were from other ethnicities (Lõhmus/Trummal, 2006).

### *1.2.2 Probation service*

Probation Supervision departments in Tallinn Prison, Tartu Prison and Viru Prison are divided into regional divisions. The probation services work with those undergoing court ordered drug and/or alcohol treatment (as a condition of their sentence), juveniles and those on early release from prison. Probation staff also provide pre-sentence reports for the courts. The main objective of probation supervision is to make society safer by implementing alternatives for imprisonment. Setting such an objective is based on a precondition that an offender can be given a non-custodial sentence, but one which involves surveillance; efforts are being made to change the person's criminogenic behaviour. Thus, probation supervision work consists of two elements – of surveillance and fostering social improvement (Ministry of Justice, 2009).

### *1.2.3 Arrest Houses*

In addition to prisons, administered by the Ministry of Justice, there are a number of 'arrest houses' administered by the Ministry of Interior (Drew et al., 2008). Arrest houses are used for those detainees expected to be held for up to 30 days while a formal charge is prepared. When suspects are charged, they may be remanded in custody by an investigating judge and sent to a special remand section of a prison. However, the Imprisonment Act of 2000 has provided the alternative of placing remand prisoners in police arrest houses. In cases where it is deemed necessary for carrying out a preliminary investigation, the police may decide that a remand prisoner should be returned to police custody from the remand prison (Stover, 2008).

## 1.3 Problem drug users in prison

Recent studies have shown that there is significant high risk behaviour occurring in Estonian prisons. Of particular concern are injecting drug use, sharing of injecting equipment and unprotected sexual contact (Stover, 2008). Indeed, the Ministry of Justice carried out the survey *Drugs in Prison* (Kikas et al., 2006) which explored prisoners' and prison officers' attitudes to and knowledge about narcotic substances across the year 2005. The purpose of the survey was to map drug use problems to plan long-term activities in the field of prevention of drug use in prisons, make suggestions for the development of appropriate rehabilitation programmes.

The findings of the survey indicate that neither prisoners or staff were certain about the proportion of prisoners using illicit drugs. However, almost a third of prisoners sampled

reported injecting drugs during imprisonment; two thirds of those reported sharing needles, less than 10% of drug-using prisoners had started using drugs in prison.

According to the findings of Kikas et al. (2006) the most widely used drugs in prison were products made from cannabis and amphetamines, followed by heroin and Fentanyl. A few respondents mentioned cocaine but added that it had been used rarely. Cannabis products were most readily available in prison during the previous 12 months, followed by amphetamines and China White (Fentanyl). Other substances were available only occasionally (Kikas et al., 2006).

### 1.4 Infectious diseases in prison

Epidemiological data indicate that Estonian prisons are settings characterized by multiple health burdens: a rapid spread of blood borne viruses (HIV, HBV/HCV), other infectious diseases (TB, STIs) and co-infections; wide-spread drug addiction; mental health issues. A substantial number of prisoners are suffering from one or more of these issues. About 20–30% of Estonia's new HIV cases are to be found in the prison system (Stover, 2008).

The first PLWHA in a penal institution was registered in May 2000. That year, 80 prisoners were found to have HIV and these formed 20% of all new HIV-cases. The majority (89%) of prisoners who are infected with HIV are men between the ages of 15 and 24. Approximately 12–13 % of all prisoners in Estonia were infected with HIV from 2004. Most had been infected before incarceration. According to data from the Ministry of Justice, there have been seven cases of HIV–transmission in the prison (one through tattooing; five through sharing contaminated syringes; and one with source unknown) (Stover, 2008).

According to the Ministry of Justice, about 15% of all prisoners in Estonian prisons were infected with HIV in 2009. In July that year, there were 638 HIV positive prisoners in Estonia and of these, 105 received HAART (Ministry of Justice, 2009). However, it is estimated that the HIV prevalence among prisoners is between 8.8% and 23.9% (Drew, 2008). HIV infection in prisons is primarily to be found among IDU's: the majority of them are male, young (between 15 and 25 years old) and Russian speaking heroin/ amphetamine users (Stover, 2008).

Since records have been taken, Estonia has had 7,128 HIV diagnosed people, including 272 AIDS cases (Health Protection Inspectorate, 2009).

### 1.5 Mental health in prison settings

There is no literature or research available on mental health issues in Estonian prisons. Mental health issues have been considered as one of the risks in Estonian prisons (Stover, 2008). Stover argues that

> additional epidemiological data describe Estonian prisons as a setting 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.

### 1.6 Alternatives to prison for problem drug users

Officially, drug addicts can have voluntary treatment instead of imprisonment. Treatment takes place with consent. No offence is needed to trigger the treatment option (EMCDDA, 2009). Due to limited treatment capacity, alternatives to prison are not widely implemented (EMCDDA, 2009).

In Estonia, imprisonment cannot currently be replaced by drug addiction treatment. The 2006 *Drug Addiction Treatment as an Alternative for Imprisonment* survey indicated that for long-term opiate addicts the easiest solution would be methadone substitution treatment (Ministry of Justice, 2007). However, available substitution treatment is not suitable as an alternative punishment as it does not include sufficient counseling and social rehabilitation. It is extremely complicated to administer alternative punishment in case of convicted youths because of the number of required stationary treatment and rehabilitation centres are limited.

At present, only people released on parole or before the prescribed time can participate in a drug addiction treatment programme when they have voluntarily undertaken the obligation to do so during the supervision of conduct (Tervise Arengu Instituut, 2007b) (according to §74 and §75 of the Penal Code).

The prosecutor can end the criminal procedure and refer an adult offender to do community service or place them under electronic surveillance and probation. However, community service can be applied to people who have been sentenced for up to two years, but this is not suitable for alcohol/ drug addicts.

Legislation provides less strict alternatives to punishment for young offenders who are still minors (14 -18 years old). One or more of the following sanctions may be imposed on a minor:

- warning;
- sanctions concerning organization of study;
- referral to a psychologist, addiction specialist, social worker or other specialist for consultation;
- conciliation;
- an obligation to live with a parent, foster-parent, guardian or in a family with a caregiver or in a children's home;
- community service;
- surety;
- participation in youth or social programs or rehabilitation service or medical treatment programmes;
- sending to schools for students with special needs.[4]

## 2.0 Throughcare services

The Ministry of Justice is responsible for administrating health care and social services in prisons. All first time offenders are recommended to take tests. HIV-test are voluntary and confidential. Testing is free of charge for prisoners (tests are paid for from the state budget through the Ministry of Justice, verification tests are paid for from the National HIV/AIDS Prevention Strategy budget). HIV-positive prisoners are in a prison pursuant to the general procedure. Further examinations and treatment are dependent on offenders' state of health. Prisons have the responsibility to organize regular training for prisoners and prison staff regarding the prevention of the spread of HIV infection. Condoms and disinfectants are also distributed to prisoners (free of charge) (UNAIDS, 2009).

[4] Juvenile Sanctions Act Passed 28 January 1998 (RT1 I 1998, 17, 264; consolidated text RT I 2002, 82, 479), entered into force 1 September 1998

All prisoners who are diagnosed with drug addiction are located in Tartu prison because it is specialized in this field. Additionally to this there are drug free zones in Viru prison and Harku prison. Prisoners can get first aid for withdrawal symptoms with non opioid treatment. All prisons have at least one psychiatrist. It is also possible to continue methadone treatment that offenders began before entering prison. Prisoners can begin methadone treatment only in Tartu prison.

Imprisonment is divided into three phases: reception phase, main phase and release phase. The objective of the reception phase is to help prisoners integrate into prison life and take part in a re-socialisation programme. In the main phase the measures indicated in the treatment programme shall be implemented. In order to facilitate prisoners' integration into society, several preparations are performed before the release. The most common preparations include provision of social assistance to prisoners and their transfer to open prison. The social worker will help prisoners to create contacts with the family and the social welfare agency. Upon release, prisoners will receive money on release, consisting of wages received for employment during imprisonment (Estonian Prison System and Probation Supervision Yearbook, 2007).

One of the key interventions in Estonian prisons is the system of 'contact persons', who form a link between prisoners and other staff, such as healthcare and specialist staff. These also assist prisoners with administrative tasks such as arranging home leave. An important part of their role is also to build a relationship of trust with prisoners, and observe them in order to be aware of health problems or incidences of bullying. They are valued by prisoners, who felt they were more accessible and available than other specialist staff, and were better equipped to assist them with problems, compared to security staff. This policy has been in place in Estonian prisons for some time and is a well developed concept and has been adopted in other prison systems (MacDonald et al., 2006).

After release, persons belonging under probation supervision are:

- A conditionally sentenced offender – a person to whom the probation period of 18-36 month is applied;
- A person released from prison prior to the expiry of the term of punishment – a person who has been released prior to the expiry of the term of punishment and with regard to whom the probation period to the extent of is applied, which is not shorter than 1 year;
- A person who has been imposed community service – a person whose up to two year's imprisonment has been substituted with his/her consent by community service. The time for community service is 24 months;
- A minor with regard to whom supervision of conduct has been applied as sanction – a minor can be released and subjected to probation supervisor's surveillance for one year. If necessary, the probation period may be extended.

The role of the probation service has developed and now has closer links with the prison service and community based organisations. Previously, it was primarily linked with the police and its role was limited to the supervision of offenders and ex-offenders. The development of this role is seen as particularly important when working with juvenile prisoners and emphasizes both the need to work in partnership with other organisations and to maintain the welfare of juveniles (Estonian Prison System and Probation Supervision Yearbook, 2007).

## 2.1 Specific needs of different groups

### *2.1.1 Women*

There is a higher prevalence of drug use amongst women than among men in prisons. This may simply reflect the situation across Europe.

Women prisoners who use drugs are exposed to physical and emotional strain, and their drug use is often a strategy to cope with experiences of prostitution, emotional, physical and sexual abuse, and violence. This mode of behaviour is not unusual for women (Stover, 2008).

### *2.1.2 Migrants/ Ethnic Minorities: Russian Speaking Prisoners*

There is generally little data available on the proportion of migrants, ethnic minorities, and displaced people using drugs in prisons. Generally, respondents claimed that non-ethnic Estonians (mostly Russian speaking prisoners) are more involved in IDU and are also disproportionally present in prisons. Migration and displacement especially are often associated with difficult living conditions, poverty, and social exclusion, which can facilitate risk behaviour in terms of sexuality and drug use. It can also have significant negative effects on the overall health of the individuals (Stover, 2008).

### *2.1.3 Juvenile Prisoners*

Although there are no epidemiological data on the prevalence of HIV/AIDS among prisoners in juvenile custody facilities in Estonia, young offenders seem to be even more at risk than their adult counterparts. This is because young people are often involved in risky drug using behaviour than adults[5].

## 2.2 Cooperation of involved agencies

There are limited agencies involved in thoughcare services. Currently there is only one NGO operating inside Estonian prisons with the aim of increasing the quality of life of HIV-positive and drug addicted prisoners.

Medical health care in Police custody and arrest houses until now has largely been provided either by nurses (in bigger institutions; these are also fully equipped) or by the community medical emergency service. In other, smaller institutions only trained officers can provide First Aid. Arrestees are seen by policemen and checked on visual injuries. No visits are allowed and no NGO is working with the detainees. Methadone treatment of drug users entering the arrest houses is interrupted.

Local family physicians provide preliminary health examinations and healthcare services. Full-time medical assistants employed by the police also carry out preliminary medical checks in detention centres. Arrestees who experience health problems whilst in custody (of the police or in arrest houses) are provided with appropriate treatment in the first instance, and if more serious problems are experienced, the emergency services will be called. Currently, the police houses do not provide any drug treatment and do not liaise with community drug treatment services (MacDonald et al 2007).

[5] Ibid.

The role of the probation service has developed and now has closer links with the prison service and community-based organizations. Previously, it was primarily linked with the police and its role was limited to the supervision of offenders and ex-offenders. The lack of services in the community is a matter of concern and probation staff emphasized the need to develop these programmes and make them available for longer periods of time.

The probation service also has a 'Family Programme', in which officers work with prisoners' families to prepare them for release and to ensure that suitable accommodation is available. This is particularly important for juveniles, who need a stable home life to prevent them from re-offending. In addition, courts can also sentence offenders to community service (a fixed number of hours of work), cautioning, attendance at special schools and mediation under victim support schemes.

One of the main NGOs that work with prisoners is Convictus Estonia. The main goals of this NGO are as follows:

- Raising prisoners' awareness of HIV/AIDS and other sexually transmitted diseases
- Increasing prisoners' tolerance towards HIV-positive persons.
- Reducing prisoners' risk behaviour.
- Monitoring ARV treatment for prisoners; improve knowledge about treatment through medical counselling.

Convictus Estonia offers counselling and information also before release. After release offenders are referred to the Convictus case management project that offers services to those with drug issues and those who are HIV-positive. Convictus has also developed a collaborative partnership with the probation office. The Ministry of Justice has been funding the services of Convictus Estonia since 2007.

### 2.4 Key challenges of effective delivery of throughcare

The key principle of equivalence between health services in prison and community settings is difficult to ensure because prison and community health systems are distinct and administered by different ministries. The main challenges are to maintain and continue the services for problematic drug users. Cooperation between the prisons and arrest houses is also challenging. Although 90% of prisoners are transferred from the arrest houses (10% are coming directly from the streets) no cooperation with nurses (or emergency doctors) is implemented. All five Estonian prisons are connected to a new electronic medical health filing system which allows information about treatment to be available to doctors when prisoners are transferred (Stover, 2008).

According to the Estonian Report to the National Response to the HIV/AIDS epidemic 2007, the main issue of concern to Estonian HIV-specialists is the lack of harm reduction facilities in the country's penal institutions. There is some agreement about the need to provide methadone treatment to prisoners; however, needle exchange still remains illegal in prisons (Estonia, 2007). Overall, the biggest barrier to the introduction of harm reduction measures in prison settings is thought to be the attitude of senior staff, who view the issue as one of the control of access to drugs. Other problems include high turnover of prison staff and the lack of continuity of services between community and prison. Services for offenders who are released from prison need to be further developed.

Other challenges include the changing nature of drug use in Estonia, including the growing use of Fentanyl and amphetamines. Services are limited for some groups of people, including pregnant women and children (Drew, 2008).

Stöver (2008) argues that the role of police and arrest houses is also challenging. There is a crucial role for police and arrest houses in dealing with drug issues, continuity of treatment and possibly the provision of harm reduction measures. Drug users are stopped/ arrested for having either clean or used syringes with them. That means that carrying/ possessing drug injection equipment is still seen as a crucial indicator of drug criminality by the police and encourages drug users to avoid carrying such equipment with them. This increases the risk of sharing needles, but no sterile injection equipment is available (Stover, 2008).

Although substantial efforts have been made to reduce the number of prisoners (currently approximately 3,600), Estonia still has the highest numbers of citizens per 100,000 population in prisons in the European Union (311), after the Russian Federation and Ukraine (Stover, 2008).

### 2.5 Gaps in provision

Estonia's national HIV and AIDS strategy clearly states that all HIV prevention services that have been implemented in the wider community should be available in prisons. This specifically includes harm reduction measures, such as needle and syringe exchange, OST and provision of condoms and lubricants. However, many of these activities are not yet being implemented in prisons and other custodial settings. Indeed, there seems to be a focus on preventing HIV transmission through improving physical infrastructure and strengthening security, to prevent illegal drug use (Drew et al., 2008).

Stöver (2008) argues that there remains a gap in motivating patients and doctors to continue their cooperation after release. Prisoners' transition from custody to community is often problematic. It is a huge problem to secure throughcare treatment across the divide between community and prison. There is a lack of throughcare and seamless provision of services for prisoners on leave and after they are released. At the point when prisoners are released, health care is likely to take lower priority than issues such as the search for housing, jobs, rebuilding personal relationships.

Prisoners should be provided with information about resources in the community and should be accompanied and assisted with enrolment for housing, health services, drug rehabilitation, financial benefits, HIV counselling and psychosocial support. Interviews with experts from prisons indicated that the continuity of treatment after release was lacking: only 50% of prisoners sought ARV–treatment in the community once being released. Essential services such as OST and the provision of sterile injecting equipment are invariably interrupted when IDUs enter the criminal justice system because these services are absent in prisons and arrest houses (Stover, 2008).

Currently, police houses do not provide any drug treatment and do not liaise with of the community drug treatment services (MacDonald et al., 2007).

### 2.6 Best practice

For several years psychological support groups in all prisons for PLWHA and drug dependent inmates in the prisons have been organised by one NGO: Convictus. In December 2002 Convictus started to work in prisons, when they received permission to work in one of the oldest and largest prisons in Estonia (Murru Vangla), where HIV-positive prisoners were housed in special isolation units. In Murru prison there were 160 HIV+ prisoners who were isolated in the so called "7th Division". This segregation policy fuelled stigmatisation, and discrimination against HIV positive prisoners, as well as an atmosphere of fear.

However, Convictus continued to organise group meetings with drug-dependent prisoners, conducted lectures and presentations for prisoners on health issues in prisons, provided pre-test counselling, developed and distributed information materials, brochures and posters, and conducted campaigns that promoted voluntary HIV testing in co-operation with medical personnel in an informal atmosphere.

With the financial support of the Global Fund (from October 2003 to September 2007), Convictus began to expand its activities to seven prisons in Estonia, finally setting up 21 support groups divided by different needs: drug-dependent men; drug-dependent prisoners, who experienced discrimination; men who have sexual relations with men; pregnant women, HIV-infected young women; minors who were dependent on illegal drugs. Each group had its own goals, tasks and members, enabling them to deal with the complexity of HIV/ AIDS. The aim of these groups is to give psychosocial help as well as to address drug and mental health issues in prison. Moreover Convictus also targets prison staff when it organises thematic awareness for HIV/AIDS (round tables) (Stover, 2008).

In addition to group work, Convictus offers a consultation service on medical issues and drug dependence. The goal of the service is to provide an individual approach to prisoners' health problems and to establish continuity in health care services oriented to HIV-positive persons and drug addicts in the prison environment and in a free society. Support groups and case management exist for HIV-positive and drug users who have recently left prison settings.

One example of good practice is that HIV testing in the Estonian prison system is completely voluntary and may be performed only with prisoners' informed consent. VCT is provided to all prisoners. As a result, about 20–30% of Estonia's new HIV cases are detected within the prison system.

### 2.7 Monitoring systems for throughcare provision

There are no special monitoring systems for throughcare provision. The Estonian Drug Monitoring Centre (EDMC) is an information and competence centre whose mission is to collect objective, reliable and comparable information concerning illicit drugs and drug addiction and their consequences at national level. The Estonian Drug Monitoring Centre participates in the work of the REITOX network. The Centre is a national information centre aimed at collecting, harmonising and analysing data on illicit drugs in Estonia, disseminating information and co-operating with EU and non-EU National Focal Points and other international bodies and organizations. According to the Estonian national Drug Prevention Strategy (2012) the main problem in monitoring the drug situation is the lack of national definitions and conceptions. There is also limited qualitative data (Estonian national Drug Prevention Strategy 2012).

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