THE IMPACT OF PRISON CONDITIONS ON PRISONERS' HEALTH

2018

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1. INTRODUCTION

Penitentiary health care has remained one of the main challenges for years. The Public Defender of Georgia has indicated serious problems in this regard in a number of reports.[1] Significant steps have been taken to improve access to penitentiary health care services since 2013, which is welcome. In order to assess the results of these efforts and to identify the prospect of further development of the system, the Special Preventive Group decided to carry out a complex, thematic study.[2]

Since the Special Preventive Group had been studying access to medical services along with other issues during its regular preventive visits, there was a need to study the penitentiary health care system with a qualitatively new methodology. Consequently, the research methodology focused not only on the provision of medical care for prisoners but on a broader definition of the right to health. The impact of prison conditions on prisoners' health was chosen as the main subject of the study, while the identification of prisoners' health risks factors was set as the main task. Prison conditions are a broad concept for the objectives of the study and covers almost every aspect of life in the Penitentiary Facility, including material conditions, regime, psycho-emotional environment, psycho-social rehabilitation and medical care.

The sociological survey of prisoners is an important component of the study. The utmost involvement of prisoners through quantitative research served the purpose of better hearing the voice of the beneficiaries of penitentiary health care system. Clearly, the penitentiary health care services are intended for prisoners. So it was interesting to measure the prisoners' level of satisfaction. One of the subjects of the study was the medical staff of the penitentiary system, as well as professional ethics, protection of which is of great importance in the service delivery process.

Within the framework of the survey, prisoners were asked questions about their experience from 2014 to 2017, while visits[3] were made to the penitentiary institutions and the sociological survey was carried out in a period between December 2016 and April 2017.

The monitoring group was staffed on the basis of a multidisciplinary principle and consisted of members of the Special Preventive Group[4] and employees of the Department of Prevention and

[1] The reports of the Public Defender of Georgia are available at: http://www.ombudsman.ge/ge/reports/national-preventive-mechanism-reports

[2] The primary project of the study was developed by Nika Kvaratskhelia, Head of the Department of Prevention and Monitoring of the Public Defender's Office of Georgia.

[3] In Penitentiary Facilities N2, N3, N5, N6, N8, N11, N14, N15, as well as the medical facility for the remand and convicted prisoners N18 and Tuberculosis Treatment Center N19.

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Monitoring[5] of the Public Defender's Office. At the preparatory stage, the monitoring team developed a monitoring methodology with the assistance of a specially invited health care expert[6] and a sociologist.[7]

Health care expert Merab Kavtaradze was involved in the preparation of the present report. Technical reports of members of the monitoring group were used along with other materials in the preparation of the report. The documents obtained during the visit, as well as the reports of the monitoring group members, are kept in the Public Defender's Office of Georgia. The report includes the main findings of the monitoring group and is designed so that to avoid identification of respondents due to the confidential nature of interviews.

During the monitoring process, members of the group checked the infrastructure of the Penitentiary Facilities and interviewed prisoners in a confidential manner. Members of the group also talked with representatives of the administration, medical personnel, social workers and psychologists of the establishments. The documentation, medical records and registers of the establishments were checked as well.

During the course of the visit, the monitoring group members were able to freely move on the territories of Penitentiary Facilities without any hindrance by the administration. The staff of the establishments presented information and documentation requested by the monitoring team.

2. GENERAL OVERVIEW

The present report is divided into two main parts. The first section reviews the penitentiary health care system, its organizational aspects, available human and infrastructural resources, disease incidence and prevalence, as well as achievements, current challenges and solutions to specific problems.

The second part of the report concerns prisoners' health risk factors and includes recommendations for eliminating these risk factors. Both sections of the report are in logical relation to each other and the issues discussed in each section are interacting. The first section describes the current situation in the penitentiary health care system, while the second section focuses on preventive health care and prevention of diseases by discussing the health risks factors, and it proposes gradual replacement of the current treatment model with preventive treatment.

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[6] Health care expert Merab Kavtaradze.

[7] Sociologist Iago Kachkachishvili.

Access to medical services has been significantly improved as a result of the reforms carried out in the penitentiary system since 2013. 37 primary health care teams and 2 medical facilities serve Penitentiary Facilities. There are drug supplies in all Penitentiary Facilities.

Equipment of the medical units of Penitentiary Facilities has been improved in recent years. It should be noted that the medical facilities were equipped with the medical devices handed to the Medical Department of the Ministry of Corrections within the framework of a grant agreement signed between the Ministry of Corrections of Georgia and the Council of Europe in 2016. Nevertheless, there are problems in terms of technical operation of the existing devices. Some complex, as well as simple devices (for example, medical scales) are out of order.

The arrangement of sterilization rooms, equipped with steam and hot air sterilizers, medical closet for sterile instruments, ultrasonic rinsing and sterile tool *packaging* devices, should be evaluated positively.

Despite the infrastructural improvement, the arrangement of rooms for storage of health care waste in accordance with standards is still a problem. It is also problematic that the rooms for X-ray examinations are not covered with barite.

As of 31 December 2016, 9,334 prisoners were placed in the penitentiary system, while the medical personnel included 191 doctors (15 chief doctors) and 265 nurses. The number of prisoners applying to medical units of the Penitentiary Facilities is high and accordingly, doctors employed in the establishments are very busy. According to the Special Preventive Group, the issue of insufficient number of nurses is particularly serious.

Despite the extremely difficult work and the inflationary processes in recent years, the wages of the medical personnel have not been raised, which decreases their work motivation. The problem of attracting new, qualified personnel is proved by the job vacancies in several establishments. For example, there is a shortage of nurses and assistants in the psychiatric unit of Penitentiary Facility N18.

It should be noted negatively that unlike other employees of the penitentiary system, the medical personnel did not have corporate health insurance packages, while their screening and early detection of diseases were of occasional nature. As it was indicated in the latest information provided by the Ministry, the problem related to medical personnel's health insurance would be eliminated from January 2018.

Certain problems are observed in continuous medical education. Systemic shortcomings in the post-diploma education of doctors are obvious in the penitentiary system. The trainings conducted and available for the medical personnel mainly concern prisoners' mental health and rights, which is very important and welcome, but high professional level and qualifications of the medical personnel and adequate management of diseases in accordance with modern standards are also very important for both doctors and patients.

It should be noted positively that the medical service of prisoners is not limited only to the services provided by doctors employed in the medical units. In case of need, prisoners are provided with the services of medical specialists of various profiles. The majority of the interviewed prisoners said that they had enjoyed the service of a primary care physician, nurse and doctor-dentist for the last three years, while they had not been in need of seeing a doctor-specialist. The most demanded doctors are: ophthalmologist (21.8%), neuropathologist (18.7%), cardiologist (18.4%), dentist-orthopedist (17%), ultrasound specialist (16.6%), psychiatrist (15.8%) and dermatology-venereology specialist (15.6%).

The survey conducted in the Penitentiary Facilities showed that the period of waiting for doctor's consultation is statistically longer in closed establishments than in semi-open establishments. On average, the waiting period in closed establishments is two times and a half as much as the respective period in semi-open establishments.

It is welcome that prisoners can enjoy medical services outside the Penitentiary Facilities as well. The survey results make it clear that the number of patients sent to Penitentiary Facility N18 for outpatient and inpatient medical services is higher in semi-open establishments compared with closed establishments. Similar tendency was observed with regard to the number of patients sent from semi-open and closed establishments to civil hospitals for inpatient medical services. The survey also showed that medical referral is mostly made to public healthcare medical facilities, which should be evaluated positively in terms of the equivalency of health care service.

The absolute majority (97.4%) of the interviewed female prisoners say that they underwent medical examination upon admission to the Penitentiary Facility, 89.7% of male prisoners also confirm the same. The absolute majority of the interviewed prisoners say that they have not been screened for noncommunicable diseases. The mentioned information could not be found in the medical records examined by the members of the Special Preventive Group either.

In order to combat infectious diseases, three important state programmes are being implemented in the penitentiary system: state programmes for tuberculosis, HIV/AIDS and hepatitis C *virus*. One of the successful projects of penitentiary health care is the tuberculosis management programme that is integrated into the state programme against tuberculosis. The service is equivalent to the programme of public healthcare system and all examinations, treatment tactics and medications are similar to the standards of the public healthcare system. The introduction of regular screenings for tuberculosis in the penitentiary system has played a major role in the fight against tuberculosis. In general, in light of the positive dynamics, special attention should be paid to the screening of resistant forms of tuberculosis and monitoring of full treatment.

Access to medicines in the Penitentiary Facilities should be praised. The interviews with prisoners showed that prisoners had been supplied with medicines through various means for the last three years of their presence in the Penitentiary Facility. 63.9% of respondents named the Penitentiary Facility as the main source of supply of medicines. 43% of the interviewed prisoners said that their families had

never sent them medicines. In addition, 40% of respondents indicated that they had never bought medicines in the drug store of the Penitentiary Facility. Only a low number of prisoners buys medicines only in the drug store and/or gets them from the family.

There has been a significant progress in the development of services in the field of physical diseases, but, unfortunately, there has not been any essential progress in the direction of mental health. The monitoring showed that the main challenge is timely identification of prisoners with mental and behavioral disorders, prevention of complications and adequate psychiatric care. Family doctors have no tools for objectively assessing the mental health of prisoners. In some cases, medical staff, despite the request of prisoners, do not refer patients to a psychiatrist, as they believe that the request is ungrounded.

The monitoring results show that the mental health services intended for prisoners are limited to the following components in practice: psychiatrist's consultation and medicinal treatment in the penitentiary facility; voluntary placement in the psychiatric unit of the medical facility for the remand and convicted prisoners; involuntary or forced psychiatric assistance in the National *Center* for Mental Health (in the village of Kutiri). Each of these components are faulty, which makes it impossible to provide adequate psychiatric assistance to prisoners.

It should also be noted with regard to the placement of patients in the National Center for Mental Health that appropriate legal procedures are delayed in a number of cases (for 9 months in some cases). Therefore, it is important that these legal procedures and practices be reviewed in order to ensure timely inpatient psychiatric care for prisoners.

According to the official data of the Ministry of Corrections, the annual rate of utilization of psychiatric services (outpatient) was 10-11 000 on average in 2014-17, indicating the busy schedule of psychiatrists employed in the penitentiary system. The monitoring results indicate the lack of personnel needed to provide adequate psychiatric care in the penitentiary system. The number of psychiatrists employed in the system is insufficient. As a result of examining the registers of consultations provided in the facility, it was found out that visiting psychiatrists often serve 25-30 prisoners per day. Obviously, all this makes it impossible to ensure adequate quality of psychiatric services.

In order to provide psychiatric care within the penitentiary system, prisoners with mental disorders are transferred to the psychiatric unit of the medical facility for the remand and convicted prisoners (N18), which is located in eastern Georgia (Tbilisi) and creates some problems in terms of geographical accessibility of the service. The psychiatric assessment and assistance in the psychiatric unit are not of multidisciplinary (bio-psychosocial) nature and are limited to mental and psychological assessment and medicinal treatment. A social worker of the medical facility is not a member of the psychiatric team and does not participate in the assessment or management of a psychiatric case. The facility does not have material or professional resources for multidisciplinary psychiatric care, psychosocial intervention. The psychiatric unit lacks mid-level qualified medical personnel. Given that there are

problems with respect to achieving patient's consent to be involved in medicinal treatment in the psychiatric unit and that patients are not provided with appropriate psychosocial rehabilitation, it can be concluded that patients cannot receive psychiatric care based on bio-psychosocial approach. Management of a psychiatric case is practically impossible under similar conditions.

After reviewing the penitentiary health care system and the progress made in this field, it is interesting to see how satisfied prisoners are with the services provided. The survey results shows that the doctors of civil sector were evaluated positively by 58.9% of prisoners, visiting doctors - by 53.2% of prisoners, medical personnel of the establishment – by 52.6% of respondents. Medical staff of the National Center of Mental Health and psychiatric unit of Penitentiary Facility N18 were evaluated negatively in this regard. The level of prisoners' satisfaction with the medical services provided outside the Penitentiary Facility varies according to sex[8], age[9] and type of establishment[10].

As for the confidence rate, it is high in the medical institutions, services of which are generally satisfactory for respondents. The level of trust in medical services provided by primary health care units of the Penitentiary Facility varies among the interviewed male and female inmates. 55.9% of female inmates trust those services, while only 49.0% of male prisoners said the same. Results were similar with regard to the medical services provided by visiting specialists.

According to the Special Preventive Group, it is important that the relationship between prisoners and doctors is similar to the relationship approved between patients and doctors. It has been established that in order to achieve the best effect, positive therapeutic relationship should be developed between doctors and patients. The medical personnel's attitude to prisoners and prisoners' trust in doctors influences the development of such relationship. It is necessary that the medical personnel observe the requirements of professional ethics. Protection of medical confidentiality remains a significant challenge in this regard. Unfortunately, a prisoner's meeting with a doctor is sometimes attended by third persons without the prisoner's consent.

As noted above, the medical personnel are very busy and the rate of utilization of various medical services is high, which is a serious financial burden for the system. Analysis of the statistical information posted on the website of the Ministry of Corrections shows that the prevalence of noncommunicable diseases in the penitentiary system has been characterized by a tendency of growth in recent years, although it remains lower compared with the prevalence of diseases of overall

[8] 31.4% of female prisoners and 15.6% of male prisoners are satisfied with the medical service provided

[9] 15% of prisoners under 46 years old and 25.1% of prisoners aged 46 and over expressed satisfaction.

[10] 73.9% of prisoners in semi-open establishments and 52.6% of prisoners in closed establishments are satisfied with this service.

population.[11] According to official statistics, diseases related to the skin and subcutaneous tissue, as well as bone-muscle system and connective tissue, are the only diseases in the penitentiary system that exceed the prevalence rate in the country.

It should also be noted that the analysis of the questionnaires on health self-assessment within the framework of the survey of the Special Preventive Group showed certain tendencies, different from the official statistics. Among the most common diseases and complaints, prisoners (prisoners between 21.7% and 15.4%) mentioned problems related to the digestive system, cardiovascular system, eyes, bone-muscle system and genitourinary system.

In addition, according to the self-assessment questionnaires, the rate (prevalence) of noncommunicable diseases in the penitentiary system is higher than it is indicated in the official statistical data and exceeds the number of diseases registered in the civic outpatient sector. For example, the official statistical data on the prevalence of arterial hypertension are lower than the data provided by the interviewed prisoners. 35.4% of the interviewed prisoners suffer from high blood pressure and more than half of them (18.6%) regularly suffer from it. The respective figure is particularly high among female prisoners. Only 40.3% of the interviewed prisoners are normotonic, 30.5% suffer from hypertension regularly, 26.0% suffer from episodic *hypertension*. Unfortunately, regardless of the fact that 49.6% of female prisoners and 36.8% of male prisoners suffer from excess weight and obesity, the medical records studied by the Special Preventive Group do not indicate a simple screening indicator, such as BMI.

According to the official data of 2014-2017, the overall prevalence in the population of mental and behavioral disorders was characterized by a growing tendency in the penitentiary system of Georgia and sharply exceeded the respective data of the public sector. The overall prevalence of mental and behavioral disorders in 2015 was 2682.5, while the respective indicator reached 9056.4 in the penitentiary system in the same period. However, it should be noted that the increase in the prevalence of mental and behavioral disorders in the penitentiary system may be caused by the improvement of the statistical data collection system, while comparison with the prevalence data of overall population may not reflect the real situation, as identification of mental and behavioral disorders is a big challenge in the public healthcare system.

According to the information received from the Medical Department of the Ministry of Corrections, the number of prisoners with mental and behavioral disorders in the Penitentiary Facilities was 1031 as of December 2015 and 1079 – as of December 2016. As for the results of the sociological survey, 26% of male prisoners and 27.7% of female prisoners interviewed in semi-open establishments need consultation with a doctor-psychiatrist. The respective indicators in closed institutions (includes a high-security prison as well) - are 35% and 38.3% respectively. According to the screening data, the respective figure is especially high among remand female prisoners - 46.8%. It should be noted that no

[11] It should be noted that the maintenance of medical statistics in the Ministry of Corrections is faulty, which is caused by problems related to medical documentation and registration of diseases.

difference has been observed between remand and convicted male prisoners. According to the Special Preventive Group, adaptation may be more difficult for women at the initial stage of detention. This may be the result of psychological traumas caused by sexual or domestic violence before imprisonment together with women's deeper emotions caused by separation from their children and family. This group of prisoners needs more attention of medical personnel, namely psychologists and psychiatrists. In addition, women under the age of 35 should be under special observation, as 41.7% of them are in need of a doctor-psychiatrist's consultation.

All of the above makes it clear that the rate of spread of physical and mental health problems is high in the Penitentiary Facilities and therefore, the demand for penitentiary health care services is high. The main task of the present study is to assess the impact of prison conditions on prisoners' health and identify the main risk factors for prisoners' health. The identification of risk factors and their elimination would enable the penitentiary system to create a healthy environment in Penitentiary Facilities and prevent diseases, which, in turn, would reduce the costs incurred by the state for the treatment of prisoners.

When talking about risk factors, it should be noted at the very beginning that, according to the survey conducted by the Special Preventive Group, some prisoners had physical and mental health problems before being placed in the Penitentiary Facility, which is often associated with their unhealthy lifestyle. The survey also identified several socio-demographic characteristics that can be seen as a health risk factor, including the low level of education, poverty and conflict with the law in the past.

According to the survey, drug use before imprisonment is a common health risk factor. About one-third of the interviewed prisoners - 30.5% (34.7% of men and 9.1% of women) indicate that they used drugs/psychoactive substances of various groups before incarceration. The majority of them, about three-quarters, were taking drugs of cannabis and opium groups (74.7% and 74.1% respectively), while 26.5% and 21.8% were taking homemade stimulants and *Ecstasy* respectively. The use of LSD, Amphetamine, Cocaine and Bio was confirmed in just few cases. It is alarming that 30 percent of drug users used cannabis and especially the opium group drugs frequently (every day or several days a week) before being placed in the Penitentiary Facility. The respective figure is 7.2% among prisoners using homemade stimulants; the use of psychoactive substances of other groups was episodic.

Another health risk factor is the use of psychotropic drugs. 38.6% of prisoners were taking psychotropic drugs in the course of the survey; 16.9% of them had started taking drugs before arrest and 21.7% were prescribed drugs during imprisonment. If we also take into account the prisoners who had been prescribed psychotropic drugs, but were no longer taking them at the time of the survey, the number of which is 39.1%, we will get an alarming figure - 77.7% of prisoners were prescribed psychotropic drugs during their presence in the Penitentiary Facility.

According to the survey, alcohol was used before arrest by 56.8% of the interviewed prisoners - 62.6% of male prisoners and 26.8% of female prisoners. 23.1% of prisoners excessively used strong drinks

containing more than 40% of alcohol before arrest; 7.9% of them consumed such drinks daily and 15.2% - several times a week. Among female prisoners, the respective indicator was 21.5%; 4.8% used such drinks daily and 16.7% - several times a week. In addition, 21.3% of male prisoners drank excessive wine (including 4.9% daily and 16.4% several times a week). The respective indicator was 14.6% among female prisoners (2.4% - daily and 12.2% - several times a week).

The survey shows that tobacco use is also a significant challenge. The number of tobacco smokers among surveyed prisoners was 75.3%. 79.1% of male and 55.6% of female inmates smoke tobacco. It is worth nothing that 6% of respondents quit smoking after being placed in the Penitentiary Facility. 13.8% of the interviewed prisoners who do not use tobacco are placed in the cell together with smokers, 43.1% of them are bothered by tobacco smoke. Smoking in the cell is very bothering for 8.9% of practically healthy prisoners and it is especially disturbing for prisoners with various diseases and their number varies between 3.9% and 28.4% according to the type of disease.

Within the framework of the survey, special attention was paid to prison food, since improper nutrition can cause substantial damage to human health. It turned out, that the majority of prisoners interviewed by the Special Preventive Group receive all the products included in the weekly menu, but some prisoners note that the amount and quality of food do not always meet the established norms.

Prisoners most often indicate the lack of fruit (22.8%), meat (16.9%) and fish (15.1%). The amounts of fresh vegetables are also small. The question – "Is there any product that you need but is unavailable in the establishment?" was positively answered by 17.9% of prisoners. Fruits and honey were most often named as such products.

The survey also shows that the quality of awareness of health care services has impact on prisoners' health self-assessment and its dynamics. The prisoners, who thought that they were fully informed about the health care services available in the penitentiary system, most often regarded themselves as practically healthy than those less or not informed.

More than half of the interviewed prisoners have not received information or received incomplete information about the health care package, as well as the procedures of specific services, healthy lifestyle or disease prevention measures, which is an essential problem. The survey showed that conditions in some Penitentiary Facilities contradict the principle of normalization, fail to protect prisoners' health or ensure respect for their private life. After analyzing the survey results, the Special Preventive Group concluded that closed space, separation of a prisoner and restrictive environment have a negative impact on prisoners' health.

When assessing their health, the prisoners who described the sanitary-hygienic conditions of their cells as satisfactory more often regarded themselves as practically healthy compared with those living in unsatisfactory conditions.

The lack of presence in the open air has a negative effect on prisoners' physical and mental health. The survey showed that 32.1% of prisoners, who daily spend time in the open air, say that they are practically healthy. Prisoners of the same group more rarely indicate severe and chronic diseases. In addition, prisoners, who daily spend time in the open air, are less prone to self-injuries, suicidal thoughts and suicide attempts. It should also be noted that the majority of prisoners (60.7%) are not engaged in exercise, sport, or other similar physical activities (on their own initiative).

The vast majority of the interviewed prisoners (80.1% -89.4%) have not participated in the rehabilitation activities. As for the desire to participate in the rehabilitation programmes, the percentage of prisoners having such desire varies between 37 and 41. According to the survey results, the percentages of people willing to participate in educational programmes differ according to the type of Penitentiary Facility. In particular, higher number of respondents in the closed facility (48.7%) are willing to participate in the programmes compared with prisoners of semi-open Penitentiary Facilities (23.6%). The same difference was observed in relation to prisoners' desire to be engaged in cultural activities, psychosocial rehabilitation programmes and sport activities. In all the three cases, the number of prisoners willing to be engaged in the programmes is higher in closed establishments than in semi-open establishments. This can be explained by the fact that prisoners in closed establishments do not have the opportunity to be engaged in leisure, artistic, labour, cognitive and other interesting activities.

Violence leads to the deterioration of health, which may last a lifetime. The survey showed that prisoners experienced violence not only in the penitentiary institution, but before arrest as well. 11.2% of the interviewed prisoners had experienced physical violence before arrest (frequency of violence varied). As for the occurrence of physical violence in the last three years after arrest (from the moment of detention by police), it was indicated by 6% of respondents (frequency varied). 9% of the interviewed prisoners indicated psychological violence before arrest and 9.7% indicated psychological violence in the past three years after arrest.

According to the Public Defender and the Special Preventive Group, the substantial risk factor of violence stems from the criminal subculture of Penitentiary Facilities. According to the informal prison rules, prisoners are not approved to report the cases of abuse committed by other prisoners and it may lead to the revenge. In many cases, the victims of such violence prefer to remain silent. The scale of psychological violence is even more difficult to establish, as prisoners may find it difficult to understand what psychological violence is. Some prisoners may think that systematic threatening is psychological violence, while the daily interaction under strict informal prison rules and conflicts among prisoners may not be understood as psychological violence. According to the Special Preventive Group, the informal prison rules and prison environment, in any case, prevents the development of a positive psycho-emotional atmosphere and is a significant stress factor.

According to the Special Preventive Group, the length of imprisonment is another important health risk factor. In case of imprisonment of up to one year, 21-23% of prisoners indicate a sharp deterioration of health. This indicator sharply increases if the length of imprisonment increases: in a group of prisoners who have been in the Penitentiary Facility for three to six years, 37% of respondents indicate the sharp deterioration of health, while in case of imprisonment for over nine years, the respective figure increases to 64%.

The length of imprisonment has significant impact on prisoners' mental health self-assessment. 15.7% of respondents indicated that they had experienced psychological/mental problems in the first six months of imprisonment. This rate reduces to 10% after the period of adaption to imprisonment (7-12 months), but then again increases twice and reaches 20%. The survey also showed a sharp correlation between the length of imprisonment and the cases of self-injuries, suicidal thoughts and suicide attempts.

Taking into consideration all of the above, the Special Preventive Group considers that the certain steps should be taken in order to maintain prisoners' health. In particular the Group recommends to : 1. Introduce an effective mechanism for controlling health care quality; 2. Ensure early identification of diseases through screening; 3. Develop adequate mental health care services and implement them in practice; 4. Introduce psychosocial rehabilitation programs tailored to prisoners' needs; 5. Relieve the regime in the Penitentiary Facilities, encourage prisoners to spend more time in the open air, be engaged in physical activities, participate in various rehabilitation activities and have contact with the outside world; 6. Promote a healthy lifestyle through carrying out information campaigns and individually working with prisoners; provide information to prisoners about the importance of preventive health care.

The Special Preventive Group takes into consideration that the measures listed above require additional financial resources, but they also believe that, since the elimination of health risk factors and disease prevention would inevitably decrease the costs of prisoners' treatment, more financial resources should be allocated for the elimination of health risk factors and prevention of diseases. This would make it possible to gradually decrease the financial burden caused by the treatment of prisoners and move to a modern, preventive health care model.

3. METHODOLOGY

The main task of the study is to assess the impact of prison conditions on prisoners' health, examine the access to penitentiary health care services and establish the level of prisoners' awareness of and satisfaction with the services. The study is also aimed at assessing the impact of reforms carried out in the field of penitentiary health care after 2013.

The measures taken for achieving the mentioned goal cover a desk research of international standards, sociological survey, interviews with representatives of prison administration, monitoring during visits to the establishments, examination of medical documentation of the establishments and statistical data processing.[12]

3.1. Sociological survey component

In order to evaluate the promotion of the protection of the right to health in the penitentiary system, the component of a sociological survey was considered within the framework of monitoring.

Statistical population of the survey: Prisoners placed in the Penitentiary Facility

Survey type: Quantitative.

Survey method: Mass survey through face-to-face interviews.

Survey tool: A structured questionnaire consisted of closed and semi-closed questions.

Sample number: 943 prisoners placed in 8 Penitentiary Facilities of the Penitentiary Department of the Ministry of Corrections.

Sampling design: Stratified sampling.

At the initial stage of the survey, a sampling scheme was elaborated, which included classification of respondents according to certain principles. The statistical population of the survey was categorized in the strata according to the following criteria:

1. **Sex:**

1.1. Women

1.2. Men

2. Age:

2.1. 45 >=

2.2. 45 <

3. Prisoner's status:

3.1. Convicted

3.2. Remand

[12] Statistical data were processed for calculating the quantitative indicator of the survey by Ms Bela Rekhviashvili.

4. Type of Penitentiary Facility:

4.1. Semi-open Penitentiary Facility

4.2. Closed Penitentiary Facility (the special facility of deprivation of liberty also included for the objectives of the survey)

Arrangement of these strata, indicating the sampling error of each of them, is shown in the table below:

Table N1	Interview	Margin of error at a 95% level of confidence
Total number of prisoners	1000	3.0%
Respondents to be interviewed according to age:		
45 >=	680	3.6%
45 <	320	5.0%
Respondents to be interviewed according to sex:		
Men	840	3.3%
Women	160	6.1%
Respondents to be interviewed according to prison status:		
Convicted	300	5.0%
Remand	700	3.5%
Respondents to be interviewed according to the type of Penitentiary Facility:		
Semi-open Penitentiary Facility	403	5.0%
Closed Penitentiary Facility	297	4.8%

Sampling according to the abovementioned parameters was arranged in the Penitentiary Facilities in the following way: (See table 2).

Table N2 Penitentiary Facilities	Interview	Age		Sex		Prisoner's status		Type of Penitentiary Facility	
		45 >=	45 <	Men	Women	Convicted	Remand	Semi-open	Closed
Penitentiary Facility N2	**209**	142	67	203	6	95	114		114
Penitentiary Facility N3	**27**	18	9	27		12	15		15
Penitentiary Facility N5	**154**	105	49		154	24	130	125	5

Penitentiary Facility N6	43	29	14	43		13	30		30
Penitentiary Facility N8	289	197	92	289		156	133		133
Penitentiary Facility N11	16	11	5	16		0	16	16	
Penitentiary Facility N14	110	75	35	110		0	110	110	
Penitentiary Facility N15	152	103	49	152		0	152	152	
Total number of prisoners	1000	680	320	840	160	300	700	403	297

However, sample categorization was modified due to the complexity of the field. See table N3.

Table N3 Penitentiary Facilities	Interview	Age			Sex		Prisoner's status			Type of establishment	
		Under 35	35-50	51 or over	Female	Male	Remand	Convicted	Convicted person charged in a new case	Semi-open	Closed
Penitentiary Facility N 2	202	90	90	22	14	188	64	138	0	6	196
Penitentiary Facility N 3	29	16	13	0	0	29	1	26	2	1	28
Penitentiary Facility N 5	105	34	45	26	105	0	22	83	0	76	29
Penitentiary Facility N 6	39	29	9	1	0	39	2	37	0	1	38
Penitentiary Facility N 8	288	139	113	36	0	288	155	130	3	1	287
Penitentiary Facility N11	12	12	0	0	0	12	0	12	0	12	0
Penitentiary Facility N14	113	46	49	17	0	113	0	113	0	113	0
Penitentiary Facility N15	155	68	70	17	1	154	3	152	0	154	1
Total number of prisoners	943	434	389	119	120	823	247	691	5	364	579

Data processing and analysis: Initially, the questionnaires filled in as a result of the fieldwork were encoded and formalized. Then the data were entered into the computer. After "clearing" the file (the first stage of statistical processing), the data were processed within the SPSS computer programme.

Univariate and bivariate analysis methods, such as frequency distribution (single-dimensional), central tendency indicators, correlation analysis and others methods were used during data processing and analyzing.

The survey is based on the assumption that analysis can be made at different levels:

- At the level of prisoners as a group with common socio-cultural characteristics and mentality;

- At the level of groups categorized according to various criteria - type of imprisonment, type of Penitentiary Facility, sex of prisoners and age of prisoners.

Accordingly, the report includes the results of the analysis made at these two levels.

On 17 November 2017, the results of quantitative research and content analysis were discussed at the meeting with representatives of the Ministry of Corrections. Representatives of the Ministry expressed their opinion on the main findings.

4. PENITENTIARY HEALTH CARE SYSTEM

4.1. Ongoing reform, legal framework and organizational aspects of the penitentiary health care

The right to health is an inclusive right[13] and includes access to safe drinking water and adequate sanitation, safe food, adequate nutrition and housing, healthy working and environmental conditions, health-related education and information, gender equality.

The right to health also includes a person's right to be free from non-consensual medical treatment, torture and other cruel, inhuman or degrading treatment or punishment. Given the content of the right to health, a person should have the right to a system of health protection; the right to prevention, treatment and control of diseases; access to medicines; reproductive health; equal and timely access to basic health services; access to health-related education and information. All services must be available, accessible, acceptable and of good quality.[14]

For the realization of the right to health, preventive health care is of special importance, which includes health promotion and improvement of general living conditions; food, sanitation, mental and physical activities, targeted preventive measures in prison in the direction of specific pathologies, such as infectious diseases, mental health, drug dependence and violence.

[13] Right to Health, Fact Sheet No. 31, Office of the United Nations High Commissioner for Human Rights and World Health Organization, available at http://www.ohchr.org/Documents/Publications/Factsheet31.pdf [accessed on 17.04.2018].

[14] General comment No 14 (2000) on the right to health, adopted by the Committee on Economic, Social and Cultural Rights.

The declared task of the Ministry of Corrections (hereinafter referred to as the Ministry) is to provide convicted/remand prisoners in the Penitentiary Facilities and convicts in the facility of restriction of liberty with adequate health care and to develop the penitentiary health care system in accordance with national and international standards.[15]

Structural units of the Medical Department of the Ministry are divisions of primary health care and outpatient services and specialized medical services, while territorial units are medical units at the places of detention and deprivation of liberty, as well as in treatment institutions. Their functions are defined by the statute of the Medical Department of the Ministry of Corrections.[16]

For the purpose of ensuring accessibility and improving the quality of penitentiary health care, the Ministry has carried out important reforms since 2013:

- The Medical Department was reorganized, electronic system of tasks and project management was introduced;
- Primary health care model was introduced in the penitentiary system; penitentiary health care standard was developed and approved, which envisages provision of medical services to the inmates at the places of detention and deprivation of liberty in accordance with the medical service requirements and international recommendations;
- The penitentiary health care budget has been almost doubled in recent years;
- The procedure for documenting patient's diagnosis was changed and is consistent with ICD-10 international diagnostic classifiers;
- The list of essential medicines of the penitentiary health care system was developed in 2013 and was renewed in 2015;
- The first stage of the penitentiary health care reform - "Human rights in prisons and other closed institutions", carried out under the auspices of the European Union and the Council of Europe, was completed;
- The Penitentiary Health care Strategy and Action Plan for 2014-2017 was elaborated and approved at the second stage;
- Food, hygiene and sanitation norms, which envisage 11 targeted rations for convicts of various physical activities, categories and health, were approved in 2015 and were later updated according to the joint order of the Minister of Labour, Health and Social Affairs of Georgia and the Minister of Corrections of Georgia;[17]
- The permit for functioning of medical facilities of the penitentiary system were obtained in accordance with civic health care requirements;
- Two medical hospitals were modernized according to modern standards: medical facility N18 for the remand and convicted prisoners, which can accommodate 57 prisoners with disabilities

[15] The statute of the Medical Department of the Ministry of Corrections, approved by the order issued by the Minister of Corrections on 25 June 2015, Article 7.

[16] Approved by the order N53 issued by the Minister of Corrections on 25 June 2015.

[17] Order N 88-N01-34/n of the Minister of Corrections of Georgia on approving the nutritional and sanitary-hygienic norms for remand and convicted prisoners, 13 August 2015.

and Tuberculosis Treatment and Rehabilitation Center (Penitentiary Facility N19). A new psychiatric unit was opened in Penitentiary Facility N18;

- Hepatitis C programme was launched in 2014;
- Treatment of tuberculosis with an updated scheme and modern anti-tuberculosis drugs was introduced in September 2015;
- In 2016, the Medical Regulation Division of the Medical Department was abolished and the function of supervision of medical services was transferred to the Medical Service Quality Control Division set up under the the General Inspectorate of the Ministry;
- The Suicide Prevention Programme has been operating in the penitentiary system from December 2013. The programme gradually covered all Penitentiary Facilitie. The programme was officially approved by the order of the Minister of Corrections of Georgia on 11 February 2016[18] and is being implemented in all establishments;
- Psycho-social rehabilitation programme Atlantis[19] has been implemented for drug-addicts since 2016;
- Job descriptions were approved both for the employees of the health department, as well as primary health care and inpatient institutions. The document determines responsibilities of the employees in detail;
- Amendments were made to about 40 legal acts within the framework of the reform;
- The electronic system of medical referral was introduced, intensive cooperation was established with civil sector clinics;
- Job descriptions were approved for the employees of the Medical Department of the Ministry of Corrections, which clearly determine the functions and responsibilities of the employees of structural and territorial units of the Department;[20]
- A procedure was developed and approved on the basis of the recommendations of the Istanbul Protocol[21] for registering the damages suffered by the remand/convicted prisoners as a result of alleged torture and other cruel, inhuman or degrading treatment in the Penitentiary Facility;
- A system of quality management, assessment of medical service quality improvement and patient safety was determined;[22]

Despite the above-mentioned positive changes, a number of problems remain in the field of penitentiary health care that will be discussed in the relevant chapters.

[18] Order of the Minister of Corrections of 11 February 2016 on approving the suicide prevention programme for the remand and convicted persons.

[19] Socio-rehabilitation programme Atlantis is being implemented in Establishments N2 and N5.

[20] Approved by order N2255 of the Minister of Corrections, 6 May 2016.

[21] Approved by order N131 of the Minister of Corrections, 26 October 2016.

[22] Approved by order N2361 of the Minister of Corrections, 6 May 2016.

4.2. Medical infrastructure and medical equipment of Penitentiary Facilitie

37 primary health care teams and 2 medical facilities are providing medical services in the Penitentiary Facilities. The health care infrastructure of the penitentiary system was renewed within the framework of the penitentiary health care reform: medical facility for the convicted and remand persons was opened,[23] the Tuberculosis Rehabilitation and Treatment Center was fully renovated, dentist's rooms were repaired and equipped in accordance with the relevant standard[24] in Penitentiary Facilitie N2, N5, N6, N7, N8, N14, N16, N17, N18 and N19, while the dentist's rooms of other establishments are now being repaired and gradually equipped.

The Public Defender's parliamentary reports have repeatedly recommended the Minister of Corrections to bring the medical units of the Penitentiary Facilitie into compliance with the standards applied in the country, including to properly equip them. Delivery of medical service in former cells remains a problem, which negatively affects the quality of service. Many medical units do not have enough natural light or proper ventilation; it is impossible to clean the surface of the walls with water; no proper sanitation or hygiene norms are observed. The primary health care unit located on the first floor of the second building of Penitentiary Facility N8 shares a wall with a shower, due to which, the walls are dampened and damaged, and the paint falls off. The room needs to be repaired.

All Penitentiary Facilities have drug supplies and every establishment has a person in charge of the drug supplies.[25] However, some of the drugs cannot meet standards.[26] For instance, drug supplies in Penitentiary Facilitie N2 and N8 are arranged so that they cannot be cleaned with water. In addition, additional small place is allocated for drugs in Penitentiary Facility N2, where no proper temperature can be kept; old furniture and materials are stored at the same place.

The arrangement of rooms for storage of health care waste is still a problem.[27] For example, Penitentiary Facility N8 has a room for health care waste, but the room is not equipped with drain or ventilation system. Penitentiary Facility N11 did not have a room for storing containers of health care waste and the bathroom of the medical personnel was used for this purpose. Rooms for medical waste were being arranged at Penitentiary Facilities N3 and N19 during the visit.

[23] Establishment N18 was opened on 1 July 2014.

[24] Response letter MOC01700166123 received from the Ministry of Corrections on 6 March 2017.

[25] Pharmacist/dispensing chemist/person with higher medical education.

[26] Government's Decree N575 of 29 September 2014 – Technical Regulation – On determining sanitary-hygienic/technical conditions of a drugstore (specialized trade facility) and a retail trade facility.

[27] Government's Decree - Technical Regulation – On approving rules of collection, storage and neutralization of waste of medical facilities. 15.01.2014.

Sterilization rooms, equipped with steam and hot air sterilizers, medical closet for sterile instruments, ultrasonic rinsing and sterile tool packaging devices were arranged in the Penitentiary Facilities.[28] It should be noted that no principle of planning[29] was observed in the sterilization room of Penitentiary Facility N18, no "clean" and "dirty" zones were separated, no principle of one-way direction of "clean" and "dirty" flows was arranged so that to prevent their intersection.

X-ray examination in the juvenile rehabilitation establishment is carried out in the manipulation room, corridor or primary health care room, while in the establishments with special space allocated for the above-mentioned, rooms cannot meet relevant standards[30] and most of them are not covered with barite.[31] There are frequent cases when no appropriate anti-radiation measures are taken or no individual effective dose of a patient is registered. Cracks can be found on the concrete floor of the X-ray room in the Tuberculosis Treatment and Rehabilitation Center, where about 100 examinations are carried out per month; the door to the crowded corridor is not protected against radiation, which creates an actual threat to both patients and personnel.

The local cleaning facilities of the medical units should be a complex of buildings providing mechanical and biological cleansing/disinfection of wastewater.[32] It should be noted that the wastewater of the medical units of Penitentiary Facilities N18 and N19 flows to the sewage system without cleansing/disinfection, which threatens not only the people present in the centers but the entire population of the country.

The artificial ventilation systems installed in the Penitentiary Facilities cannot provide optimal conditions of microclimate or air environment. Penitentiary Facilities N18 and N19 are particularly problematic in this regard, since the faulty ventilation system cannot ensure the protection of the sanitary-epidemiological conditions of the hospital, which increases the risk of the spread of nosocomial infections.

Even though the space in the chambers of the inpatient units of Penitentiary Facilities N18 and N19 is in compliance with the norm established by the Imprisonment Code - 4 m², it cannot meet the standard established by the rules and conditions for issuing a permit for an inpatient facility, according to which, the space in the chamber should be at least 8 m² per patient. [33] Therefore, it is important that amendments be made to the Imprisonment Code and the relevant subordinate acts in order to ensure

[28] Sterilization rooms were arranged in Establishments N2, N5, N6, N8, N14, N15 and N18, sterilization rooms were being arranged at Establishments N3 and N19.

[29] Government's decree N 185 of 24 April 2015, Technical Regulations on disinfection and sterilization in public health facilities and institutions of public importance, Article 4.

[30] Government's decree N317 of 7 July 2016, Technical Regulations – Radiation safety requirements in the field of medicine.

[31] In Establishments N5 and N8.

[32] Government's decree №294 of 16 June 2017, Technical Regulations – Management of medical waste; Article 9.

[33] Government's decree N385 of 17 December 2010 – Approval of regulations on rules and conditions for issuing license for medical activity and permission for inpatient facility.

that the space per patient is at least 8 m² in the medical establishments. The psychiatric unit of Penitentiary Facility N18 and the unit of tuberculosis and infectious diseases are located on one and the same floor and are connected to each other through an open corridor, which creates a risk of the spread of infection.

Equipment of medical units of the Penitentiary Facilities with medical devices has been improved in recent years. It should be noted that within the framework of the grant agreement signed between the Ministry of Corrections of Georgia and the Council of Europe in 2016, medical devices were handed over to the medical department.[34] Despite the apparent progress in equipping the establishments, the devices needed for urgent medical service are still insufficient. Most of the establishments, including Penitentiary Facility N19 that provides inpatient service, do not have defibrillators, which makes it impossible to provide full-scale urgent care. It is important the medical units of the Penitentiary Facilities to have the opportunity to provide urgent medical care and shock therapy.[35]

The lack of ultraviolet bactericidal device (quartz lamp) in Penitentiary Facility N19 prevents the protection of sanitation in the high-risk stores. The surgery room of Penitentiary Facility N2 is not equipped with appropriate medical (surgical) lighting system, which makes it difficult to carry out even minor surgical manipulations.

Problems are observed in terms of technical effectiveness of the existing devices as well. Some of the medical devices, both simple (e.g. medical scales) and complex devices, are out of order. The biochemical analyzer had not been operational in Penitentiary Facility N18 for a long time, due to which, it was necessary to send samples to the civil sector lab for routine biochemical examination, which requires more time and finances.

In addition to the above, the X-ray device of Penitentiary Facility N18 has been out of order over a year and X-ray examinations are carried out with a portable device that does not always ensure the quality necessary for inpatient diagnostic examination. The facility has to carry out X-ray examinations in the civil sector facility, which, apart from preventing timely diagnostics and treatment, is related to additional expenses. The X-ray device of Penitentiary Facility N19 also has technical problems. The Ministry has not made a decision relating to the compulsory calibration of medical devices (except laboratory analyzers) either.

[34] Reply MOC31600966804 received from the Ministry of Corrections of Georgia on 25 November 2016.

[35] Minimal requirements for outpatient service providers and classification of medical interventions approved by order N01-25/n of the Minister of Labour, Health and Social Affairs of Georgia on 19 June 2013.

It is important to equip medical units of the Penitentiary Facilities and arrange them like civil outpatient service providers.[36] In addition, it is necessary to make a list of devices, mandatory medicines and medical materials necessary for the medical units of the Penitentiary Facilities.

Recommendations to the Minister of Corrections:

- **Bring the medical units of the Penitentiary Facilities into compliance with the standards applicable in the country[37], including by properly equipping them and controlling the medical equipment, regulating the ventilation system and providing antistatic linoleum**
- **Arrange the drug supplies of the Penitentiary Facilities in accordance with he relevant standard[38]**
- **Allocate waste rooms with appropriate temperature, large bins, washbasins and water supply systems in all Penitentiary Facilities[39]**
- **Arrange X-ray rooms[40] equipped with individual dosimeters to control the radiation of both the personnel and patients, as well as all devices necessary for exposing x-ray materials, in all establishments**
- **Arrange sterilization space in all Penitentiary Facilities in accordance with the standard applicable in the country [41]**
- **Make a list of devices, mandatory medicines and medical materials necessary for medical units in all Penitentiary Facilities.**

4.3. Human resources

According to the information provided by the Medical Department of the Ministry of Corrections, as of 31 December 2016, 9,334 remand/convicted persons were placed in the penitentiary system, while the medical personnel included 191 doctors (15 chief doctors) and 265 nurses. It should be noted that the total number of medical personnel has not significantly changed compared with 2015.

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[36] Minimal requirements for outpatient service providers and classification of medical interventions approved by order N01-25/n of the Minister of Labour, Health and Social Affairs of Georgia on 19 June 2013.

[37] Order N233/n of the Minister of Labour, Health and Social Affairs of Georgia of 6 October 2003 - "Rules of arranging, equipping and exploiting various outpatient-policlinic facilities.

[38] Government's Decree N575 of 29 September 2014 – Technical Regulation – On determining sanitary-hygienic/technical conditions of a drugstore (specialized trade facility) and a retail trade facility.

[39] Government's Decree - Technical Regulation – On approving rules of collection, storage and neutralization of waste of medical facilities. 15.01.2014.

[40] Government's decree N317 of 7 July 2016, Technical Regulations – Radiation safety requirements in the field of medicine.

[41] Government's decree N 185 of 24 April 2015, Technical Regulations on disinfection and sterilization in public health facilities and institutions of public importance.

The number of doctors and nurses in the penitentiary system according to the data of 2016 is given in the table below.

	Penitentiary Facility	Doctor	Nurse	Person in charge of drug supplies
1.	Penitentiary Facility N2	11	16	1
2.	Penitentiary Facility N3	6	5	1
3.	Penitentiary Facility N5	7	9	1
4.	Penitentiary Facility N6	7	11	1
5.	Penitentiary Facility N7	4	4	1
6.	Penitentiary Facility N8	28	44	1
7.	Penitentiary Facility N9	4	9	1
8.	Penitentiary Facility N11	3	4	1
9.	Penitentiary Facility N12	3	6	1
10.	Penitentiary Facility N14	10	11	1
11.	Penitentiary Facility N15	10	18	1
12.	Penitentiary Facility N16	2	5	1
13.	Penitentiary Facility N17	10	19	1

Table 1. The number of doctors and nurses according to the Penitentiary Facilities

See the relation between the number of doctors and nurses and the number of prisoners in 2016 according to the establishments in the diagram:

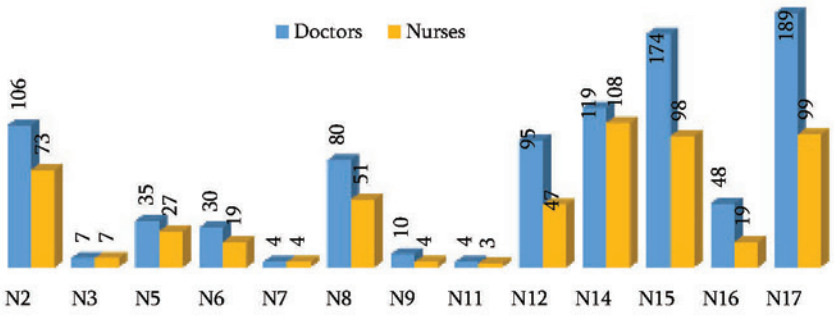

Diagram 1. Quantitative relation between the medical personnel and prisoners; number of prisoners per doctor, per nurse

According to the recommendation of the European Committee for the Prevention of Torture, staffing levels should be equivalent to one medical doctor for 300 prisoners and one qualified nurse for 50

prisoners.[42] The diagram shows that the quantitative relation between the number of prisoners and nurses in Penitentiary Facilities N2, N14, N15 and N17 is high and accordingly, it is necessary to hire more nurses.

134 people, including 61 doctors, 2 pharmacists, an assistant pharmacist and 70 nurses are employed in the medical unit of the medical establishment for remand and convicted prisoners (N18) of the Ministry of Corrections of Georgia; 63 people, including 26 doctors, a pharmacist, 2 assistant pharmacists and 34 nurses are employed in the medical unit of the Tuberculosis Treatment and Rehabilitation Center.

Staffing the penitentiary system with qualified medical personnel is one of the problems. Despite the inflationary processes in recent years, wages of the medical personnel have not been raised, which decreases work motivation. It should be noted that the medical personnel who live far from their workplace, for example the employees of Penitentiary Facilities N15 and N19, are not reimbursed for the transportation cost, which is an additional financial burden for them. The Public Defender considers that increased wages would significantly enhance the motivation of the staff employed in the system and would attract qualified specialists.

The problem of attraction of new employees is proved by the job vacancies in several establishments. For example, there is a shortage of nurses and assistants in the psychiatric unit of Penitentiary Facility N18. Only one nurse works during the night shifts and holidays, while one of the nurses has to work without an assistant. According to the head of the unit, they could not hire a new employee as the job vacancy did not turn out to be attractive.

Medical and non-medical personnel are under the same risks as prisoners; the risk of infection is high among medical personnel. It is alarming that unlike other employees of the penitentiary system, the medical personnel did not have corporate health insurance packages, while screening and early detection of diseases were of occasional nature. As it was indicated in the latest information provided by the Ministry, the problem related to medical personnel's health insurance would be eliminated from January 2018. It is welcome that from 1 January 2018, the medical personnel of the Penitentiary Facility have been able to enjoy health insurance.

Nutrition of medical personnel is also problematic. As there is no food or catering facilities on the territory of the Penitentiary Facility, the personnel have to bring food in from outside, which somewhat affects the epidemiological situation. According to the Special Preventive Group, in many cases, they found the food of the medical staff stored along with drugs and reactants in the refrigerators of the medical facilities.

[42] 2007 Report of the European Committee for the Prevention of Torture (CPT) regarding the visit paid to Greece in 2007, par. 52, available in English at: https://rm.coe.int/16806965ea [accessed: 11.05.2018]

Interviews with medical personnel made it clear that they cannot bring drugs for personal use in the establishments, which creates additional difficulties for some of them. At the meeting with representatives of the Ministry of Corrections, it was noted that doctors were only allowed to bring in the medicines prescribed by a doctor and certified by a medical document on health condition.[43]

Due to the inexistence of a normative base regulating the issue of bringing personal medicines in the territory of the Penitentiary Facility by medical personnel, regulation of the issue depends on the good will of the administration of the Penitentiary Facility, which creates significant discomfort for the medical personnel.

Primary health care units are not equipped with computers. In case of need, doctors have to use the computer in the room of a chief doctor, but due to the restrictions on the Internet, the medical personnel lacks the opportunity to get comprehensive information about modern methods of diagnostics and treatment, guidelines, protocols and medications. "Informational isolation" of the medical personnel carries certain risks, which is reflected on the quality of medical care. In addition, the lack of motivation prevents the introduction of new practical or theoretical skills or modern methods of treatment.

Certain problems are observed in continuous medical education. Systemic shortcomings in the post-diploma education of doctors are obvious in the penitentiary system. Trainings conducted and available for medical personnel mainly concern the mental health and the rights of prisoners, which is very important and welcome, but high professional level and qualifications of medical personnel and adequate treatment of diseases in accordance with modern standards are also very important for both doctors and patients. Practically, no trainings are conducted in this direction. Doctors are not provided with modern guidelines or protocols. According to one of the doctors, she uses the guidelines transferred to her during passing the course of a family doctor several years ago. Phthisiologists represent an exception, as they have constant contact with the specialists of public healthcare system and Penitentiary Facility N19. They are provided with modern guidelines and protocols, and trainings are often conducted according to their specialty, which should be evaluated positively. It is important that the medical personnel of other fields be regularly trained in their specialties like phthisiologists.

Doctors incompletely and defectively maintain medical documentation. Namely,

- The dynamics of health condition of prisoners is partly or improperly reflected in medical records;
- Medical records partially provide or do not provide information about the doctor-specialist's consultation or prescription;
- Information about the prescription or medicines is scarce;

[43] Working meeting held with representatives of the Ministry of Corrections on 17 November 2017 within the framework of the Open Society Georgia Foundation project - Promotion of the Right to Health in Penitentiary Facilities.

- Indication of diagnoses on a separate paper of a medical record using the ICD-10 classifier are incomplete, namely, no chronology is observed, while in some cases the diagnoses of a doctor or a consultant are not indicated. This not only creates a problem in terms of full treatment of prisoners, but also hinders the process of collecting and analyzing comprehensive statistical data and planning medical processes;
- In some outpatient medical records, the handwriting of primary care physicians and consultants is illegible, which makes it difficult to correctly understand and interpret the records;
- Records rarely contain information on preventive examinations conducted;
- Management of specific diseases is reflected in a faulty manner in outpatient medical records.

The faulty outpatient medical records make it difficult to evaluate the dynamics of prisoners' health condition for years. It is desirable a summarizing/annual epicrisis[44] to be made at the end of each year, which would briefly reflect the dynamics of prisoner's health, consultations, referral, examinations, diagnoses, treatment and its results. The introduction of more modern electronic information system acceptable for the medical personnel and the entire penitentiary system should be seen as an alternative to the above-mentioned initiative, which would eliminate the problems related to medical documentation as much as possible and would ensure collection, exchange and availability of full and reliable medical information necessary for patient's examination, treatment and further analysis.

The visit to the Penitentiary Facility showed that there is a high demand for doctor's consultation among prisoners, which according to doctors, is often caused not by health condition, but by prisoners' desire to psychologically relax and make their days a bit different, something understandable for doctors, considering human, bio-ethical factor. They explain that such visits have a somewhat psychotherapeutic effect, although such communication, which goes beyond their duties, requires more time and prevents the performance of their immediate duties. As a result, the primary care physicians are mainly busy with dealing with minor medical problems of the prisoners and have less time to solve more serious medical problems. This may have some impact on the quality of medical care. According to the doctors, taking prisoners for a walk and filling up their free time with other activities would be a great relief for both prisoners and medical personnel.

Recommendations to the Minister of Corrections:

- **Develop and implement an active policy for attracting new staff; for this purpose, provide information to the public about job opportunities and working conditions in the Penitentiary Facilities**

[44] Doctor's conclusion, comprehensive written explanation about the source, development and progress of the disease, as well as form and results of its treatment, see the link: http://www.nplg.gov.ge/gwdict/index.php?a=term&d=13&t=4051 [accessed: 11.05.2018]

- Raise the wages of the medical personnel by at least 20% in 2018 and then by at least 10% every year
- Ensure transportation of the personnel to the Penitentiary Facility
- For the purpose of providing timely and adequate medical care, the ratio in all Penitentiary Facilities should not exceed the following: 1 doctor per 300 prisoners and 1 nurse per 50 prisoners
- Define the rule of bringing personal medicines in the Penitentiary Facilities by the medical personnel at the normative level
- Ensure availability of food on the territory of the Penitentiary Facility for the medical personnel
- Ensure that primary health care units are equipped with the required number of computers and internet
- Provide doctors with updated medical guidelines and protocols that are in compliance with international standards
- In order to rectify the shortcomings in the outpatient medical records:
    - Ensure that a summarizing/annual epicrisis is made at the end of each year in order to briefly reflect the dynamics of a prisoner's health for the past year, consultations conducted, referral, examinations, diagnoses, treatment and its results
    - Introduce information system acceptable for the medical personnel and entire penitentiary system in order to eliminate flaws related to medical documentation
- Introduce morning clinical conferences in all Penitentiary Facilities in order to discuss complex cases and exchange experience among doctors.

4.4. Medical service

4.4.1. Primary health care

The provision of health care for prisoners is a state responsibility. Prisoners should enjoy the same standards of health care that are available in the community.[45]

Prisoners in the penitentiary system are served by 37 primary health care units and two treatment facilities. In 2016, the Medical Department had signed contracts with 49 clinics of civil sector to get equivalent medical care. The medical units, which operate in all Penitentiary Facilities, provide prisoners with 24-hour medical service. The medical personnel of the Penitentiary Facility calls ambulance in cases of need for urgent medical assistance.

[45] The Nelson Mandela Rules, Rule 24

In total 152 865 outpatient consultations were provided in the penitentiary system throughout 2016, including 99 278 - by primary care physicians, 40 646 - by various medical specialists and 10 555 - by psychiatrists. 2 392 outpatient consultations were provided in civil sector clinics in the same period. The rate of delivery of dental services was 16 555 in the same period.[46]

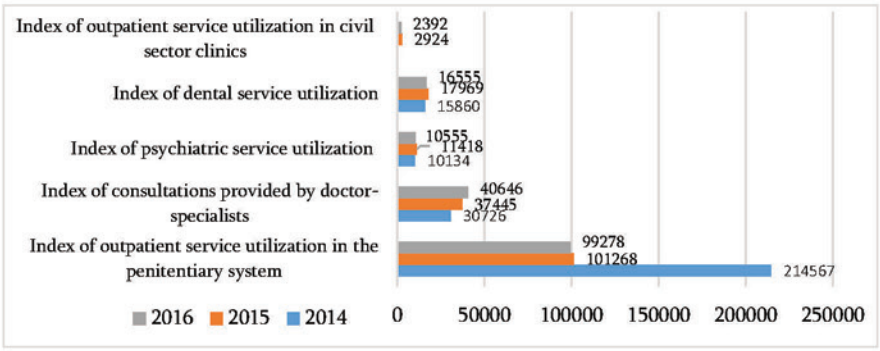

Diagram 2. The rate of the utilization of outpatient medical services

The official statistics of the civic health system do not include cases of informal treatment and self-treatment, which undoubtedly affects the data on utilization of medical services. An average of 15.3 outpatient visits were counted per prisoner in the penitentiary system in 2016, which is almost four times and a half as much as the number of visits registered in civic sector (3,4 visits).[47] This difference may be even bigger - according to the official data, primary care physicians serve only 4-5 patients per day, while according to the data provided by the doctors of the Penitentiary Facilities, they consult on average 12-15 patients per day. Such a difference between the data may also be caused by the faulty system of registration of prisoners' visits.

4.4.2. Supply of medicines to the Penitentiary Facilities

The medicines enlisted as essential medicines are purchased through a tender and are supplied to the Penitentiary Facilities upon a monthly request.[48] The establishments are also supplied with medicines necessary to treat viral hepatitis C and tuberculosis, as well as antiretroviral medicines. In case of need, the medicine necessary for a particular prisoner may be purchased through a simplified procedure upon

[46] According to the statistical data posted on the website of the Ministry of Corrections. See the link http://www.moc.gov.ge/ka/statistika/yovelthviuri-angarishi [accessed: 18.04.2018]

[47] National Center for Disease Control and Public Health, Health Care - Statistical Data; pg. 70; table N2.6. see the link http://www.ncdc.ge/Handlers/GetFile.ashx?ID=e6187208-0a3f-4026-a25e-d72fa93ec51a [accessed on 14.04.2018]

[48] Amendments to order №31 (22 April 2015) of the Minister of Corrections on approving the standards of medical service in prisons and places of restriction of liberty, additional standards of medical service of persons with specific needs, the preventive service package for prisons and places of restriction of liberty and the list of essential medicines for the penitentiary system.

the chief doctor's request. Prisoners also have the right to get medicines from family members or buy them at the drug store located on the territory of the Penitentiary Facility.[49]

In most cases, the Penitentiary Facilities provide prisoners with medicines, while the cases when prisoners buy medicines in the drug store[50] located on the territory of the establishment or get them from family members are rarer. It is important not to restrict the prescription of medicines available at the establishment and to ensure that in case of a prisoner's request, in agreement with a doctor and at the expense of a prisoner, brand medicines can be sent to prisoners without any obstacle.

Interviews with prisoners showed that prisoners had been supplied with medicines through various means for the last three years of their presence in the Penitentiary Facility. 63.9% of respondents named the Penitentiary Facility as the main source of supply of medicines. 43% of the interviewed prisoners said that their families had never sent them medicines. In addition, 40% of respondents indicated that they had never bought medicines in the drug store of the Penitentiary Facility. Only a low number part of prisoners buys medicines only in the drug store and/or gets them from the family.

The practice of exchanging information on excess medicines among the Penitentiary Facilities should be evaluated positively. The person responsible for drug supplies provides information about excess medicines to other establishments each month and sends medicines in case of need. The supply of medicines to the establishments is mainly satisfactory, although there are some shortcomings. Problems relating to the supply of medicines, as a rule, emerge at the beginning of the year, when the supplies run out, but no new medicines are yet purchased due to the terms of a tender. The supplies start to be filled only from mid-February. Before that, prescribed medicines are substituted with other medicines of same action.

During the visits, there were no cough medicines in Penitentiary Facilities N2 and N8. Doctors said during interviews that probiotics Adaptol, Donormil and Melaxen had not been available in the establishment for the last two months. In similar situation, primary care physicians often have to refer prisoners to psychiatrists, as the sleeping pills they are allowed to prescribe are not available in the establishments. Antibiotics such as Coclav and Levofloxacin (and their substitutes) are supplied in small amounts and run out soon in the establishments. There are periodical gaps in the supply of materials as well.

Storing psychotropic medicines is also problematic. For example, psychotropic medicines were put on an open shelf like other non-psychotropic medications in Penitentiary Facility N8, which is a violation

[49] Response MOC71700217079 received from the Ministry of Corrections on 22 March 2017.

[50] There are drugstores at Establishments N8 and N15, where prisoners can buy drugs.

of a standard.[51] Expired medications are another problem. In particular, expired medications are not kept in a sealed box and it is delayed to write them off.

4.4.3. Medical specialists' consultations

Prisoners in the Penitentiary Facilities are provided with the service of medical specialists of various profiles. Depending on the needs of the establishment, within the framework of an agreement signed with the Ministry of Corrections, medical specialists periodically provide consultations to prisoners in the Penitentiary Facilities. Despite the increasing number of such consultations, which reached almost 50% of consultations provided by primary care physicians in the last two years, a number of problems still remain unsolved (see table N2).

Name of preventive and treatment measures	*2014*	*2015*	*2016*	*2017 6 months*
The number of consultations provided by primary care physicians	214567	101268	99278	40599
The number of consultations provided by medical specialists of various profiles (except psychiatrists, dentists and primary care physicians)	30726	37445	40646	20093

Table 2. The number of consultations provided by primary care physicians and specialists of various profiles according to years

Prisoners' appointments with narrow profile medical specialists are recorded in a consultation register. In some cases, the information is faulty - either lacks the date of making an appointment, the date of a doctor's visit or the date of a consultation. The consultation registers of several Penitentiary Facilities (N3, N5 and N8) include only the data on the patients consulted, which makes it impossible to evaluate whether consultations were timely provided. In case of transfering a prisoner to another establishment or primary health care unit, an appointment is not redirected and the prisoner has to wait for his/her turn anew.

Problems related to consultations with medical specialists of various profiles vary according to the establishments. For example, doctors' visits to Penitentiary Facility N2 are well organized: visits are made regularly on a fixed day, once a week, according to a schedule. Consultations are provided by an ophthalmologist, infectionist, neurologist, otolaryngologist, radiologist, ultrasound specialist, pediatrician, surgeon, traumatologist, gynecologist and dermatologist. The period of waiting for a consultation is minimized and the number of patients to be consulted is optimal. The only exception is

[51] Decree N150/N of the Minister of Labour, Health and Social Affairs of 21 July 2003 on approving the rules of legal circulation of drugs, psychotropic substances and precursors in pharmaceutical, medical, training, medical-research, expert-diagnostic and control-analytical laboratory, orphanages and institutions for persons with disabilities".

the consultation of an orthopedist-dentist, which had not been provided for the last 2-3 months during the last monitoring;[52] the consultations of urologists and proctologists were also problematic, as they were provided only once a month. Consultations in Penitentiary Facility N8 are not regular and the waiting period is long. In addition, the services rendered to patients in Penitentiary Facility N 8 are different in each primary health care unit and the waiting periods are also different. All this depends on the motivation of a primary care physician. Patients in primary health care units should be equally treated and timely delivery of medical care should not depend only on the motivation or activeness of a doctor.

The majority of the interviewed prisoners said that they had enjoyed the service of a primary care physician, nurse and doctor-dentist for the last three years, while they had not been in need of seeing a doctor-specialist. The most demanded doctors were: ophthalmologist (21.8%), neuropathologist (18.7%), cardiologist (18.4%), dentist-orthopedist (17%), ultrasound specialist (16.6%), psychiatrist (15.8%) and dermatology-venereology specialist (15.6%).

According to the interviewed prisoners who requested medical consultation, the fastest appointments were made with a psychiatrist, phthisiologist, gynecologist, surgeon, cardiologist and infectionist in a few days after request (over 60% of cases). The number of respondents who had to wait for a consultation for two or more months was quite high. In this case, consultations of an ophthalmologist, urologist, proctologist, ultrasound specialist, endocrinologist, traumatologist and gastroenterologist had the highest rates (more than 15% of cases).

Which specialist's consultation had you requested for the last three years of your presence in the Penitentiary Facility? (%) **(N=943)**	I had not requested	I requested	**How long did you have to wait for the consultation after request?**					
			Several days	Several weeks	One month	Two months or longer	Pending	It is difficult to answer the question
Ophthalmologist	78.2	21.8	45.2	20.9	17.1	16.6	0.5	3.3
Neuropathologist	81.3	18.7	40,4	18.2	17.1	12.3	2.1	4.8
Allergologist	93.1	6.9	52.2	2.9	24.6	13.0	1.4	4.3
Cardiologist	81.6	18.4	61.4	13.6	9.2	10.9	0.5	4.9
Urologist	86.7	13.3	34.6	22.6	18.0	18.0	2.3	4.5
Proctologist	95.7	4.3	44.2	9.3	20.9	16.3	2.3	7.0
Surgeon	89.3	10.7	69.2	12.1	6.5	11.2	0.0	0.9
Infectionist	94.6	5.4	64.8	7.4	3.7	13.0	1.9	7.4
Radiologist	86.2	13.8	57.2	15.2	12.3	13.0	0.7	1.4
Oncologist	97.9	2.1	4.8	23.8	14.3	23.8	14.3	19.0
Dermatology-venereology specialist	84.4	15.6	47.4	10.9	17.9	13.5	2.6	7.7
Phthisiologist	96.1	3.9	64.1	12.8	2.6	12.8	0.0	10.3

[52] A visit was made to Establishment N2 on 5-10 April 2017.

Ultrasound specialist	83.4	16.6	53.6	16.3	7.8	15.1	1.2	6.6
Psychiatrist	84.2	15.8	72.8	9.5	7.0	8.2	0.6	1.9
Narcologist	97.9	2.1	57.1	4.8	14.3	9.5	0.0	14.3
Outerinolaryngologist	93.6	6.4	34.4	14.1	26.6	15.6	1.6	7.8
Endocrinologist	92.8	7.2	31.9	25.0	18.1	18.1	2.8	5.6
Angiologist	97.0	3.0	36.7	13.3	26.7	13.3	3.3	6.7
Traumatologist	96.7	3.3	30.3	27.3	18.2	21.2	0.0	3.0
Rheumatologist	96.1	3.9	25.6	35.9	23.1	10.3	0.0	7.7
Gynecologist	94.7	35.0	64.2	18.9	5.7	7.5	0.0	5.7
Breast Physician	96.5	21.6	40.0	11.4	20.0	5.7	2.9	20.0
Gastroenterologist	95.2	4.8	54.2	8.3	10.4	18.8	2.1	6.3

Table 3. The waiting period for a doctor-specialist's consultation

The waiting period in closed establishments is statistically longer than in semi-open establishments. On average, the waiting period in closed establishments is two times and a half as much as the period in semi-open establishments.

At the beginning of the year (January), the consultation process was somewhat interrupted, which was caused by the delayed signing of annual contracts with doctor-consultants. Consultations were unavailable in this period.

During their visits to the Penitentiary Facilities, medical specialists sometimes have to consult many prisoners per day, which affects the quality of consultation. Most medical records are incomprehensive; they do not contain diagnoses or prescriptions, while in some cases, it is even impossible to read the records.

4.4.4. Medical referral

The Ministry of Corrections of Georgia signed contracts with medical facilities of civil sector in order to ensure that prisoners are provided with full, quality and equivalent medical assistance. Patients are taken to the mentioned facilities for outpatient or inpatient care in case of need. According to the data of 2016, contracts were signed with 49 medical facilities of civil sector.

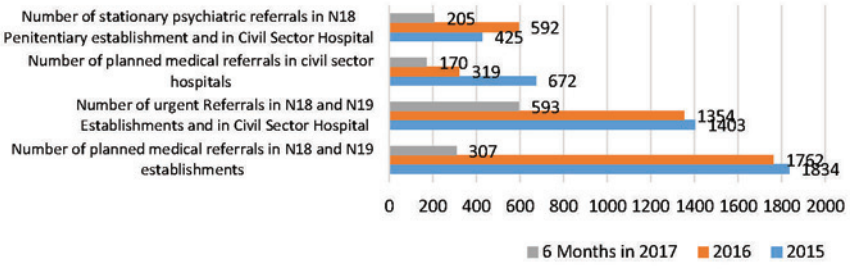

Diagram 3. The number of referrals according to years

The Special Preventive Group studied the timing of the medical referral during the monitoring conducted in the penitentiary institutions. It should be positively noted that timely confirmation of a case by the Medical Department during registering the case in the electronic database has not been a problem from the second half of 2016.

A section of a delayed urgent intervention was added to Decree N55 of the Minister of Corrections of 10 April 2014, which implies that a referral should be made in 2-5 days considering the prisoner's health condition. The amendment is welcome and the Public Defender hopes that the same change will be made to Decree No 31 of the Minister of Corrections of 22 April 2015 as well.[53]

The survey showed that 17.1% of the surveyed outpatient respondents had been taken to a civil sector hospital and 9,6% - to Penitentiary Facility N18. As for the inpatient service, 12.8% had been transferred to a civil sector hospital and 8.4% - to Penitentiary Facility N18.

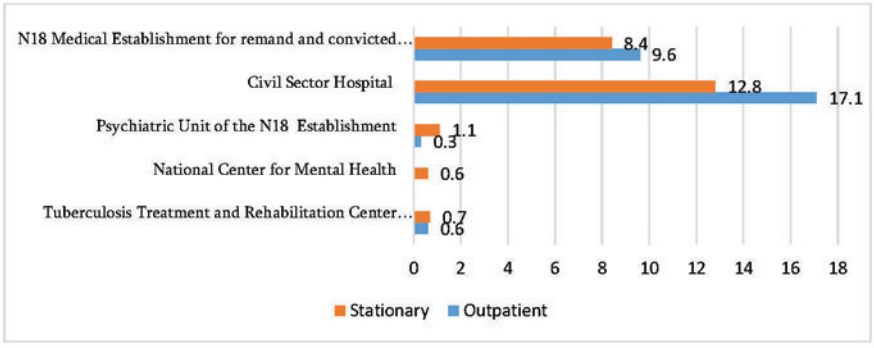

Diagram 4. Medical service provided outside Penitentiary Facilities

The number of female prisoners (16,2%) who were provided with outpatient medical treatment in Penitentiary Facility N18 was more than the number of male prisoners (8,4). The number of female prisoners who were provided with outpatient medical treatment at the civil hospitals was also high in comparison with male prisoners. In addition, the number of convicted persons who received outpatient medical services both in Penitentiary Facility N18 and civil hospitals was higher than the respective indicator among remand prisoners.

[53] Order №31 (22 April 2015) of the Minister of Corrections on approving the standards of medical service in prisons and places of restriction of liberty, additional standards of medical service of persons with specific needs, the preventive service package for prisons and places of restriction of liberty and the list of essential medicines for the penitentiary system.

Have you been treated ...		Status of a prisoner	
		Remand	Convicted
At the Penitentiary Facility N18 (outpatient)	Yes	3.8%	12.1%
	No	96.2%	87.9%
At the civil hospital (outpatient)	Yes	5.6%	22.4%
	No	94.4%	77.6%
At the Penitentiary Facility N18 (inpatient)	Yes	1.7%	11.5%
	No	98.3%	88.5%
At the civil hospital (inpatient)	Yes	3.1%	17.2%
	No	96.9%	82.8%

Table 4. Medical service provided outside Penitentiary Facilitie

It is clear from the results of the survey that the number of patients sent to Penitentiary Facility N18 for outpatient and inpatient medical services is higher in semi-open Penitentiary Facilities compared with closed Penitentiary Facilities. Similar tendency was observed with regard to the number of patients sent to the civil hospitals for inpatient medical services. 17.5% of the surveyed prisoners of semi-open Penitentiary Facility and 9.8% prisoners of closed Penitentiary Facilities were taken to the civil hospitals for inpatient medical service.

Some of the interviewed prisoners, who received outpatient and inpatient services at the medical facilities of the Penitentiary Department and civil hospitals, indicated the time needed for getting the medical care. The average waiting period for outpatient treatment/examination was 16 days in Penitentiary Facility N18, 34 days - at the civil hospitals and 18 days - in the Tuberculosis Treatment and Rehabilitation Center (Penitentiary Facility N19). As for the regular inpatient treatment, the average waiting period for the interviewed prisoners was 77 days in Penitentiary Facility N18 and 33 days - at the civil hospitals. As for the urgent inpatient treatment, the average waiting period was 25 hours in Penitentiary Facility N18 and 17 hours - at the civil hospitals.

			Number	Waiting period
Outpatient (day)		Penitentiary Facility N18	77	15.65
		Civil hospitals	136	33.66
		Psychiatric unit at the prison hospital	1	
		Khoni mental health facility	0	
		Tuberculosis Treatment and Rehabilitation Center (Penitentiary Facility N19)	6	17.83
I-patient	Regular (day)	Penitentiary Facility N18	53	77.63
		Civil hospitals	69	33.74
		Psychiatric unit at the prison hospital	8	104.30
		Khoni mental health facility	4	103.14

		Tuberculosis Treatment and Rehabilitation Center (Penitentiary Facility N19)	5	97.99
	Urgent (hour)	Penitentiary Facility N18	26	25.25
		Civil hospitals	50	17.26
		Psychiatric unit at the prison hospital	2	0.51
		Khoni mental health facility	0	
		Tuberculosis Treatment and Rehabilitation Center (Penitentiary Facility N19)	0	

Table 5. Waiting period for referral procedure

The survey showed that medical referral is mostly made to the public sector, which should be positively evaluated in terms of health care service equivalency.

Recommendations to the Minister of Corrections:

- **Analyze the data on application of medicines in recent period and take into view the results both during the wholesale purchase of medicines and supply of a specific Penitentiary Facility with medicines, in order to eliminate the shortcomings related to the supply of medicines**
- **Doctors should not be restricted to prescribing only the medicines available in the Penitentiary Facility and in case of a prisoner's request, brand medicines should be made available at the expense of a prisoner. In case of absence of a drug store in the Penitentiary Facility, the rule of sending medicines to the Penitentiary Facilities should be clearly defined**
- **Provide a schedule of doctor-consultants' visits to the Penitentiary Faciliti and ensure that they visit Penitentiary Facilitie once a week, in order to ensure timely and adequate medical care**
- **Ensure effective management of medical purchases, make analysis of cost-effectiveness and evaluate the quality of penitentiary health care services through predetermined valid indicators**
- **Outline a plan for integrating penitentiary health care with civic health care; prior to the implementation of the plan, promote independence and competitiveness of the medical personnel through continues professional training, strengthening various training module, assessing sustainability of the trainings and elaborating a supervision mechanism**
- **Develop a procedure of providing a consultation by medical personnel at the normative level**
- **Ensure that the Medical Service Quality Control Division supervises the procedure of provision of consultations by the medical personnel through monitoring. In order to implement this, relevant amendments should be made to Decree N25 of the Minister of Corrections of 25 June 2015.[54]**

[54] Decree N25 of the Minister of Corrections of 25 June 2015 on the Approval of Regulations of the General Inspectorate of the Ministry of Corrections of Georgia.

4.4.5. Medical confidentiality

Medical records and other medical documentation are kept in the primary health care room of the Penitentiary Facilitie and only medical personnel have access to them. Protection of confidentiality has been facilitated by the termination of the practice of providing medical consultations in prison cells. However, a number of problems still remain in relation to the protection of medical confidentiality in the Penitentiary Facilities.

Attendance of third persons at consultations without the consent of a prisoner is the most common form of the violation of medical confidentiality. The meetings between doctors and patients are attended by non-medical staff in the interests of safety of the medical personnel. According to the survey results, only 45.2% of the interviewed prisoners indicated the absence of non-medical staff in the room, while 48.5% said that the medical examination was attended by other employees of the Penitentiary Facility and in some cases by other prisoners (5,3%) without their consent.[55]

For example, all meetings between a psychiatrist/psychologist/nurse and psychiatric patients at the psychiatric unit of Penitentiary Facility N18 are attended by a security guard, which prevents the development of a positive therapeutic connection between doctors and patients. During the visit of the Special Preventive Group to Penitentiary Facility N2, the medical manipulation of a prisoner was attended by security guards and other prisoners.

According to the data, the percentage of the respondents whose meetings with doctors were attended by other persons varies according to the type of the Penitentiary Facility. For instance, 34.4% of respondents of the semi-open Penitentiary Facility said that other staff was present at the meeting with a doctor, while the respective figure was 57% in the closed Penitentiary Facility. This may be caused by the regime of the Penitentiary Facility. In particular, prisoners of the closed facility cannot move independently and must be accompanied by an employee of the facility when leaving a cell. Regardless of the regime of the Penitentiary Facility, it is important the meeting between a doctor and a patient not to be attended by third persons.

The interviewed prisoners evaluated observation of professional ethics and confidentiality by medical personnel. The findings of the survey show that the doctors of civil sector were evaluated positively by 58.9% of prisoners, visiting doctors - by 53.2% of prisoners, medical personnel of the Penitentiary Facilities – by 52.6% of respondents. Medical staff of the National Center of Mental Health and psychiatric unit of Penitentiary Facility N18 were evaluated negatively in this regard.

[55] During interviews with members of the Special Preventive Group at Establishment N15, one of the doctors indicated that there were convicts who helped them to control the queue of consultations. According to him, since all convicts know each other, proper protection and control of the queue is difficult.

When assessing the observation of professional ethics and confidentiality in medical Penitentiary Facilities, prisoners' opinions differ from each other according to prisoners' sex, age, status and type of Penitentiary Facility. In comparison with male prisoners, most female prisoners note that both primary health care centers and visiting specialists observe professional ethics[56] and confidentiality. In addition, statistically sound connection was observed between the type of Penitentiary Facility and the evaluation of the observation of professional ethics and confidentiality by medical institutions. Specifically, many prisoners placed in semi-open Penitentiary Facilities said that primary care physicians and visiting specialists observed professional ethics and confidentiality, while only a small number of prisoners interviewed in closed-type Penitentiary Facilities said the same.[57]

In addition, it should be noted that the medical personnel of the medical establishments with relatively higher rates of confidence and general satisfaction showed the highest rate in terms of observation of professional ethics and confidentiality.

The survey showed that treatment without a patient's informed consent occurs only seldom. Majority of the interviewed prisoners (91.7%) have never been treated without their or their family member's written consent.

4.4.6. Prisoners' general satisfaction with medical services

Patient satisfaction is one of the most important indicators of the quality of medical service. The recommendations of the World Health Organization regards patient satisfaction as a necessary component for the development of the quality of medical service.

The survey shows statistically sound relation between the prisoners' general satisfaction with medical services and the trust towards medical personnel. The confidence rate is high in the medical institutions, services of which are generally satisfactory for the respondents.

50.5% of the interviewed prisoners trust the primary health care units of the Penitentiary Facility and 22.2% do not trust it. As for the visiting doctors, they enjoy confidence of 50.8% of respondents, while 20.2% do not trust them. Civil Hospitalsare trusted by 60.6% of respondents and distrusted by 12.7%.

[56] 61.5% of the interviewed female prisoners indicate that medical personnel of the establishment observe medical ethics, while in case of male prisoners, only 33.8% indicated the same. As for the visiting doctor-specialists, 54.9% of the interviewed female prisoners believe that they observe professional ethics, while only 30.3% of male prisoner share this opinion.

[57] 51.2% of the interviewed prisoners in semi-open establishment indicate that medical personnel of the establishment observe medical ethics, while 30% of the interviewed prisoners in closed establishment said the same. As for the visiting doctor-specialists, 48.4% of prisoners interviewed in semi-open establishments indicated that doctor-specialists protected professional ethics, the respective figure was 25.3% in the closed establishment.

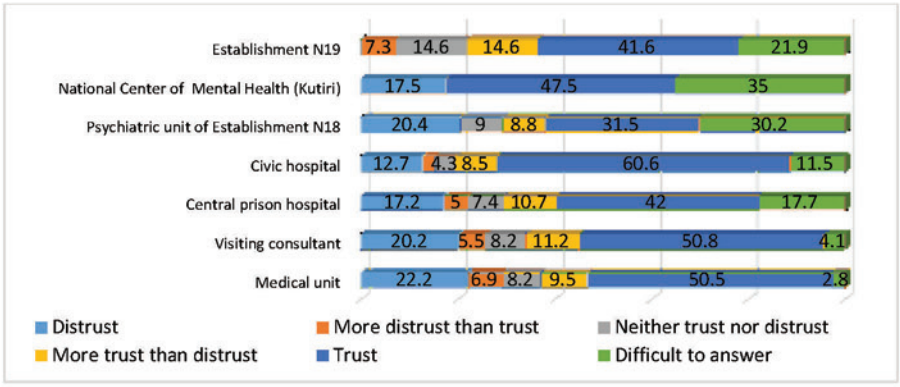

Diagram 5. Prisoner's trust indicator

The level of confidence in medical services provided by the primary health care unit of the Penitentiary Facility varies among the interviewed male and female inmates. 55.9% of the female inmates trust their service, while only 49.0% of male prisoners expressed confidence. Results were similar with regard to the medical services provided by the visiting specialists.

The correlation analysis showed that trust in visiting specialists increases with the prisoner's age. The higher the prisoner's age is, the higher the confidence is, and the lower the prisoner's age is, the lower the confidence is in the visiting medical professionals. It is also interesting that the medical services provided by the primary health care unit of the Penitentiary Facility and visiting specialists are more trusted by convicted prisoners than remand prisoners.

Most of the interviewed prisoners (62.9%) are satisfied with the medical services provided in the civil hospitals. 49.3% of respondents are satisfied with the services provided in the primary health care unit of the Penitentiary Facility and 52.2% of the respondents are satisfied with the services provided by visiting specialists in the Penitentiary Facility. 15.2% of the interviewed prisoners indicate that they are not satisfied with the services provided at the primary health care unit of the Penitentiary Facility and 15.8% of the respondents expressed dissatisfaction towards visiting doctors. 7 to 29% of the interviewed prisoners said they were dissatisfied with the medical services provided at civil hospitals, Penitentiary Facility N18, psychiatric unit of Penitentiary Facility N18, the National Center of Mental Health and the Tuberculosis Treatment and Rehabilitation Center (Penitentiary Facility N19). It should be noted that most prisoners (29.3%) complained about the medical service provided in the psychiatric unit of the facility for the remand and convicted prisoners (Penitentiary Facility N18).

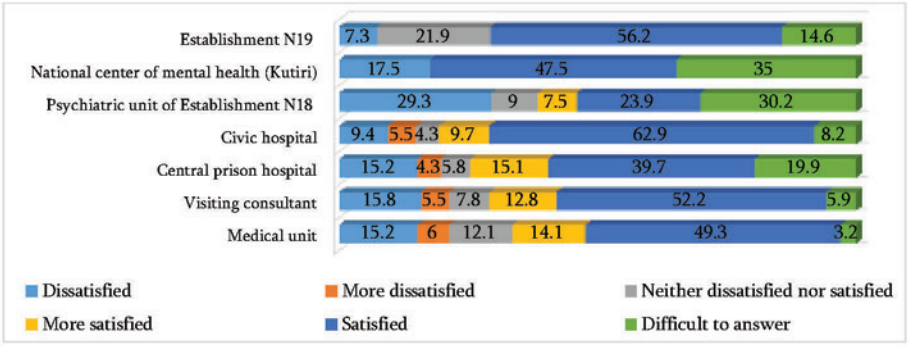

Diagram 6. Prisoners' satisfaction with medical service

The survey showed that the level of prisoners' satisfaction with the medical services provided outside the Penitentiary Facility varies according to sex[58], age[59] and type of Penitentiary Facility.[60] As for the level of satisfaction with civil hospitals, virtually no difference was observed in the answers of remand and convicted prisoners.

More than half of the interviewed female prisoners (57.9%) expressed satisfaction towards primary health care unit of the Penitentiary Facility, while only 47% of male prisoners were satisfied with the same service. As for the level of satisfaction with the medical services provided by the visiting specialists at the Penitentiary Facility, more male prisoners expressed satisfaction than women.

The correlation analysis showed that dissatisfaction with the medical services provided by the visiting specialists or primary health care unit of the Penitentiary Facility are mostly expressed by prisoners aged 51 and over. The level of dissatisfaction decreases with age.

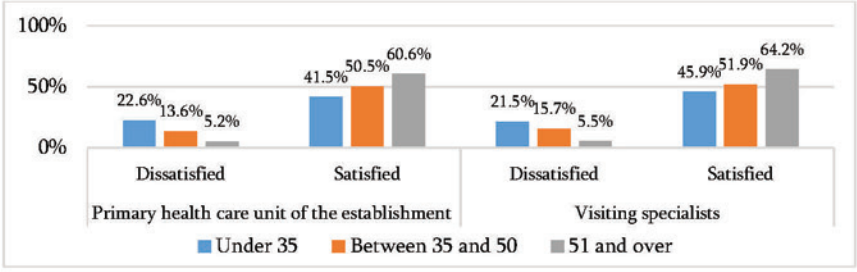

Diagram 7. Satisfaction according to age

[58] 31.4% of female prisoners and 15.6% of male prisoners are satisfied with the medical service provided

[59] 15% of prisoners under 46 years old and 25.1% of prisoners above 46 expressed satisfaction.

[60] 73.9% of prisoners of the semi-open establishment and 53.6% prisoners of the closed establishment are satisfied with this service.

Recommendations

To the Minister of Corrections:

- **Analyze the normative base for the purpose of ensuring confidentiality of medical information**
- **Ensure that the Medical Service Quality Control Division checks, through regular monitoring, where and how medical documentation are kept, as well as who has access to them**
- **Draft a legislative amendment to Article 24 (2) of the Imprisonment Code in order to remove the provision under which a document on compulsory medical examination of a prisoner upon admission to the establishment is kept in his/her personal (non-medical) file. In addition, ensure that this package is submitted to the Government for its further submission to the Parliament**
- **Ensure strict supervision over the observation of ethical principles by the medical staff of the Medical Service Quality Control Division of the General Inspectorate of the Ministry of Corrections and adequate response to the violations**
- **Ensure direct contact between prisoners and doctors without involvement of non-medical personnel, including though installing call buttons in closed Penitentiary Facilities and obliging the medical personnel to daily visit cells.**

To the Parliament of Georgia:

Make an amendment to Article 24 (2) of the Imprisonment Code and remove the provision under which a document on compulsory medical examination of a prisoner upon admission to the establishment is kept in his/her personal (non-medical) file. Such a document should be kept in the prisoner's medical record.

4.5 Prisoners' health

4.5.1. Noncommunicable diseases

It has been universally recognized that noncommunicable diseases represent an acute problem for public health throughout the world. Cardiovascular diseases, malignant tumors, diabetes mellitus and chronic respiratory diseases are the four most common diseases. According to the data of the World Health Organization, 70% of deaths are caused by these diseases in the world.[61] Even though noncommunicable diseases have a global impact on people of any nationality, age and income, there is

[61] Noncommunicable Diseases, Progress Monitor 2017, see the link: http://apps.who.int/iris/bitstream/10665/258940/1/9789241513029-eng.pdf?ua=1. [accessed on 14.04.2018]

a clear disproportion in the spread of the mentioned diseases, especially among the vulnerable groups of the population.

Analysis of the statistical information posted on the website of the Ministry of Corrections shows that the prevalence[62] of noncommunicable diseases in the penitentiary system has been characterized by a tendency of growth in recent years, although it remains lower compared with the prevalence of diseases in the overall population.[63] Diseases related to the skin and subcutaneous tissue, as well as bone-muscle system and connective tissue, are the only diseases in the penitentiary system that exceed the prevalence rate in the country (see table N6).

	population	Penitentiary system		
	2016	2015	2016	2017 5 months
Cancers	2378.4	118.0	140.5	369.5
Thyroid diseases	2786.2	804.7	1148.6	1223.9
Diabetes mellitus	3033.6	1198.1	1215.4	1444.3
Nervous system diseases	4217.0	3069.2	3725.1	3648.6
Eye diseases	5202.1	2271.8	3374.6	4127.2
Ear and mastoid diseases	2443.6	1029.2	1282.2	1398.1
Vascular diseases	16405.6	5730.3	7652.3	9396.5
Respiratory diseases	21425.8	5740.8	6823.0	8659.6
Diseases of the digestive system	15044.9	10211.7	10831.8	12501.3
Diseases of the skin and subcutaneous tissue	2375.9	3538.5	4847.7	5036.2
Diseases of the bone-muscle system and connective tissue	4086.3	3469.1	5127.9	5720.6
Diseases of the genitourinary system	6134.6	4558.9	5901.7	6591.8

Table 6. Prevalence of noncommunicable diseases in the penitentiary system according to the classes of diseases

According to the prisoners' answers, many diseases have been detected during their presence in the penitentiary system, especially pathologies, such as diseases relating to the skin, eye, ear, nose and throat, as well as genitourinary diseases, proctologic diseases, chronic lung diseases and tumor diseases. The cause of the above-mentioned may be the conditions and risk factors in the penitentiary system

[62] High number of diseases, see the link: http://www.nplg.gov.ge/gwdict/index.php?a=term&d=13&t=10682 [accessed on 30.05.2018]

[63] It should be noted that maintenance of medical statistics is faulty at the Ministry of Corrections that is caused by problems related to the medical documentation and registration of diseases.

that facilitate development of diseases on the one hand and higher utilization of medical services and detection of earlier diseases in the penitentiary system on the other hand (see diagram N8).

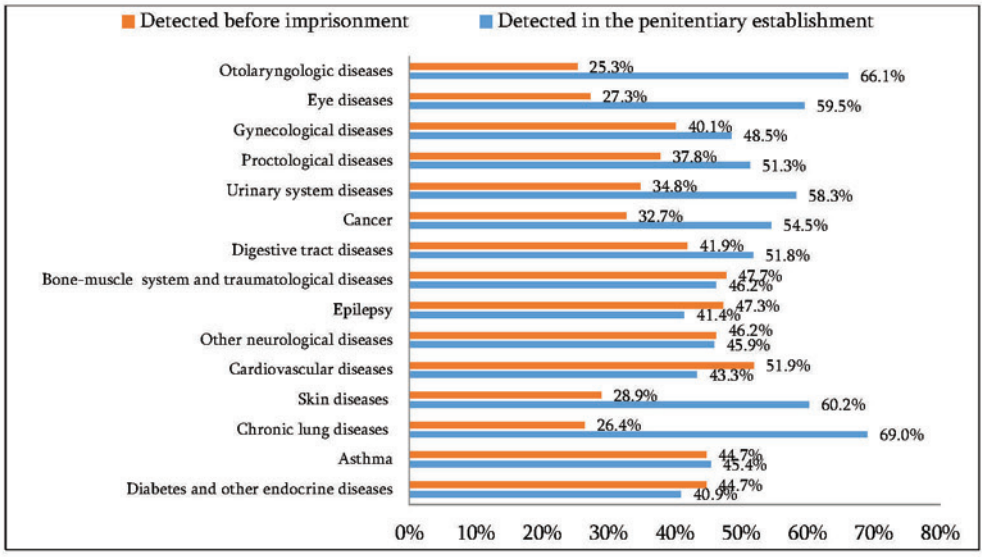

Diagram 8. Index of detection of noncommunicable diseases

Many surveys have proved the objectivity of health self-assessment and it has been recognized as an effective predictor of chronic diseases and death cases, as well as a tool for planning the needs of medical service.[64]

The analysis of the questionnaires on health self-assessment shows certain tendencies, different from the official statistics. Among the most common diseases and complaints, prisoners mentioned problems related to the digestive system, cardiovascular system, eyes, bone-muscle system and genitourinary system (21.7% - 15.4% of prisoners).

Prisoners in the semi-open establishments more frequently talk about the diseases related to the digestive system, cardiovascular system, eyes and bone-muscle system, as well as diabetes and other endocrine diseases, asthma and tumor.

Compared with the prisoners of semi-open establishments, prisoners of closed establishments more frequently suffer from epilepsy, genitourinary system diseases, chronic lung diseases and skin diseases,

[64] DeSalvo KB, Bloser N, Reynolds K, He J, Muntner P: Mortality prediction with a single general self-rated health question. A meta-analysis. J Gen Intern Med 2006, 21:267-75.

which may be related to the conditions characteristic of closed establishments, where prisoners spent an hour or less in the open air and are not involved in physical activities.

	In total	Semi-open establishment	Closed establishment	Men	Women	Civil sector, outpatient, 2016*
Arterial hypertension	35.3%	38.4%	33.5%	31.2%	56.5%	9.7%
Digestive system diseases	22.0%	24.0%	20.7%	19.5%	35.3%	15.1%
Cardiovascular diseases	21.7%	23.1%	20.9%	17.8%	41.8%	16.4%
Eye diseases	18.2%	19.5%	17.5%	16.8%	24.8%	5.2%
Bone-muscle system diseases	17.0%	20.3%	14.9%	15.3%	25.5%	4.1%
Genitourinary diseases	15.4%	13.1%	16.8%	16.0%	11.8%	6.1%
Skin diseases	9.7%	7.8%	10.8%	8.9%	13.7%	2.4%
Diabetes and other endocrine diseases	9.1%	12.5%	7.0%	4.8%	31.2%	2.7%
Ear, nose and throat diseases	8.8%	8.6%	8.9%	8.2%	11.7%	5.3%
Proctological diseases	6.3%	5.8%	6.5%	6.7%	3.9%	-
Other neurological diseases	5.4%	4.7%	5.8%	5.6%	4.6%	4.2%
Epilepsy	3.1%	1.7%	3.9%	3.5%	0.7%	0.4%
Chronic lung diseases	3.6%	1.9%	4.6%	3.8%	2.6%	1.2%
Asthma	3.4%	4.5%	2.7%	2.3%	8.5%	0.3%
Oncological diseases	2.8%	3.6%	2.2%	1.6%	8.4%	-

Diagram 9. Frequency of the spread of noncommunicable diseases according to the prisoner's self-assessment

Data analysis in the context of sex shows that some noncommunicable diseases are more frequent among female prisoners. Among them are: digestive, cardiovascular, eye, bone-muscle, skin, tumor, diabetes and other endocrine diseases and asthma (see the table).

The frequency of these diseases increases with age, except for epilepsy, skin, ear, nose and throat diseases.

The high rate of epilepsy among prisoners can be caused by the head injuries resulting in the loss of consciousness indicated in 8.7% of the anamneses of the interviewed prisoners. Over half of such prisoners (58.4%) indicate that they had lost consciousness for the past three years, while 23.2% of them relate their epilepsy seizure to the head injuries.

It is concerning that prisoners often name beating[65] in the Penitentiary Facilities and police stations as the cause of their head injuries (24.9% and 10.0% respectively). It should also be noted that prisoners

[65] During the survey, the interviewed prisoners indicated that they had been beaten before 2012, which left serious health problems for them.

of closed establishments indicate "beating in the Penitentiary Facility" as the cause of their head injury more often (27.4%) than prisoners of semi-open establishments (21.5%).

According to the self-assessment questionnaires, the number (prevalence) of noncommunicable diseases in the penitentiary system is higher than it is indicated in the official statistical data[66] and exceeds the number of diseases registered in the civic outpatient sector.

The low rate of prevalence of noncommunicable diseases among prisoners in the official statistical data may be caused by the faulty medical documentation and disease registration, which was detected during the visits of the Special Preventive Group to the penitentiary system - in many cases the episodes of diseases were not fully reflected in medical records or were only found in the notes of medical records instead of its special page, where all the diagnoses should have been reflected. Such an attitude may be caused by the failure to realize the existing risks; in addition, noncommunicable diseases may not be seen as a serious problem.

The official statistical data on the prevalence of arterial hypertension are lower than the data provided by the interviewed prisoners. 35.4% of the interviewed prisoners suffer from high blood pressure and more than half of them (18.6%) regularly suffer from high blood pressure. The respective figure is particularly high among female prisoners. Only 40.3% of the interviewed prisoners are normotonic, 30.5% suffer from hypertension regularly, 26.0% suffer from episodic hypertension (see diagram N10).

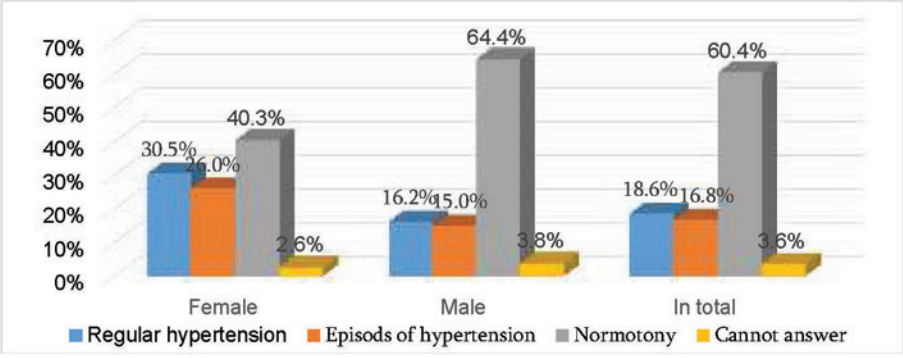

Diagram 10. Occurrence of arterial hypertension

There is a correlation between the frequency of the detection of arterial hypertension and prisoners' body mass index (BMI) (see diagram N11). People with obesity suffer from high blood pressure twice as frequently compared with those with normal BMI.

[66] Statistical data on the website of the Ministry of Corrections http://moc.gov.ge/ka/statistika/yovelthviuri-angarishi

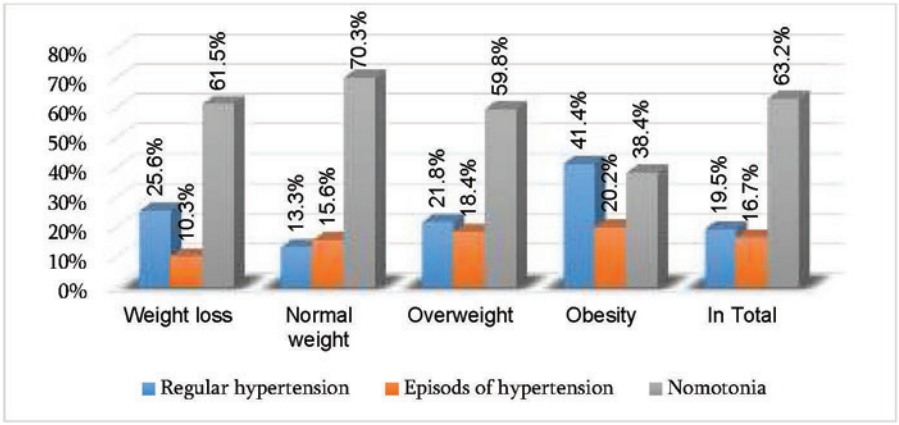

Diagram 11. Correlation between arterial hypertension and BMI

Unfortunately, regardless of the fact that 49.6% of female prisoners and 36.8% of male prisoners suffer from excess weight and obesity, the medical records studied by the Special Preventive Group do not indicate a simple screening indicator, such as BMI (see diagram N12).

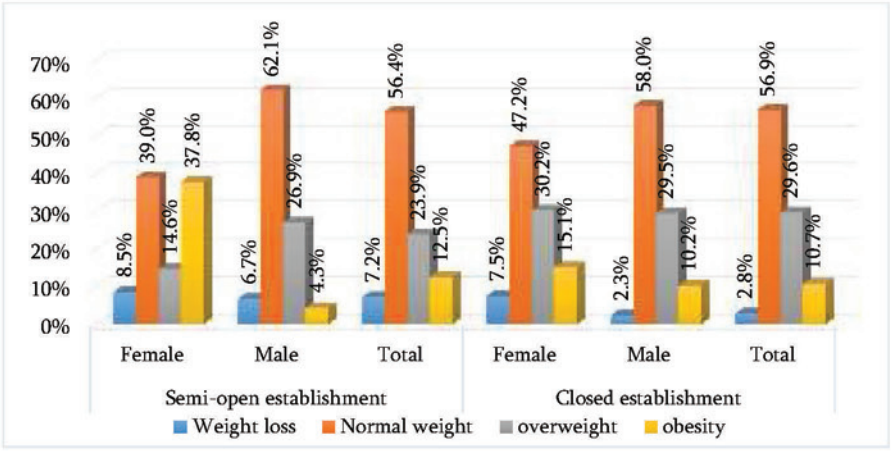

Diagram 12. Body mass index

It should be noted that body mass index does not provide only nutritional information. It has certain correlation with patients' physical and psychological risk factors.

91% of the interviewed prisoners point out that they underwent medical examination upon admission to the Penitentiary Facility. Only 8,3% of the interviewed prisoners say that no primary medical examination was conducted. It should also be noted that in most cases the primary medical examination

of prisoners is superficial, the proof of which is the results of the survey - some prisoners note that the primary medical examination was limited to a conversation with a doctor.[67]

The survey showed statistically sound relation between the medical examination and the prisoner's sex. In particular, the absolute majority (97.4%) of the interviewed female prisoners say that they underwent medical examination upon admission to the Penitentiary Facility, 89.7% of male prisoners also confirm the same.

The faultiness of preventive examination and early detection of noncommunicable diseases is proved by the dynamics of screening examinations. The necessity and periodicity of screening of noncommunicable diseases is determined by the order of the Minister of Corrections[68] and includes screening for nosologies, such as screening for colon cancer (FOBT test, colonoscopy), cardiovascular disease risk assessment (calculation of BMI and blood glucose, lipid metabolism (total cholesterol - HDL, international normalized ratio -INR), screening for diabetes (measurement of blood glucose), screening for hearing and vision (consultation, audiometry), screening for abdominal aortic aneurysm (ultrasound investigation of abdominal cavity). Unfortunately, the order has not been fulfilled. The absolute majority of the interviewed prisoners say that they have not been screened for noncommunicable diseases. The mentioned information cannot be found in the medical records examined by the members of the Special Preventive Group either.

The rate of screening of female prisoners is also low. Important examinations, such as Pap test and mammography, have not been provided even for the half of the female prisoners. The low level of a simple procedure, such as breast self-examination, can be explained by the lack of awareness of female inmates.

Unlike noncommunicable diseases, some of the screening examinations of infectious diseases are more systematic and cover more prisoners.

There is no unified procedure of health assessment of a prisoner upon his/her admission, which would make it easier to get full screening information. It is desirable to introduce an internationally recognized standard procedure to be filled in when a prisoner is admitted to or leaves a facility and which would include complete medical information for the civic health care system.

[67] 29.2% of the interviewed patients said that their primary medical examination was limited only to a conversation with a doctor.

[68] Order №31 (22 April 2015) of the Minister of Corrections on Approving the standards of medical service in prisons and places of restriction of liberty, additional standards of medical service of persons with specific needs, the preventive service package for prisons and places of restriction of liberty and the list of basic medicines for the penitentiary system.

4.5.2. Communicable Diseases

Correct management of Communicable Diseases is one of the cornerstones of the penitentiary health care system. Health of not only prisoners but of the whole community depends on it. The penitentiary system in non-favorable conditions may become a hub of infections for the community.

In order to combat Communicable Diseases, namely infectious diseases, three important state programmes are being implemented in the penitentiary system: state programmes for tuberculosis, HIV/AIDS and hepatitis C virus.

One of the successful projects in the penitentiary health care is the tuberculosis management programme that is integrated into the state programme against tuberculosis. The service is equivalent to the programmes and all examinations, treatment tactics and medications are similar to the standards of public healthcare system.

The decrease in tuberculosis incidence[69] over the last years indicates the efficiency of the programme. There were 457 cases of tuberculosis in 2012, 66 - in 2014, 65 - in 2015, 49 - in 2016 and 24 – in the 5 months of 2017. The pace of decrease in the number of patients infected with tuberculosis is significantly higher in the penitentiary system than in the population.[70] Despite the effectiveness of tuberculosis treatment, it should be noted that acute shortness of breath caused by tuberculosis was indicated as the death cause in the conclusion of the National Forensic Bureau in two cases of deaths reported in the Penitentiary Facilities in 2017. These cases are to be taken into consideration since both of them were detected in semi-open establishments.

Introduction of regular screening for tuberculosis in the penitentiary system has played a major role in the fight against tuberculosis. Primary examination of prisoners is conducted upon their admission to the Penitentiary Facility and repeated examination is conducted once in every 3 months. In case of suspicious cases, additional diagnostic examinations are conducted - X-ray examination, bacteriological analysis of sputum and rapid molecular (genotypic) tuberculosis diagnosis - Xpert MTB/RIF test, which simultaneously detects M.tuberculosis and defines resistance to Rifampicin.

6.8% of respondents said they were or had been affected by tuberculosis; 79.3% of them said they had already completed the treatment course. No difference was observed between prisoners of semi-open and closed establishments. The survey also showed the observance of the principle of continuity of treatment. If a prisoner being treated for tuberculosis is released, a notification is sent to the National

[69] Frequency of new cases of diseases among certain population within a certain period of time; see the link: http://www.pain.org.ge/definitions/dictionary.php [accessed on 28.05.2018]

[70] According to the data of the National Statistics Office of Georgia, 3329 cases of tuberculosis, including 2615 new cases, were registered in Georgia in 2016.

Center for Tuberculosis and Lung Disease; obligatory registration of patients is controlled by the National Center for Tuberculosis.

73.4% of respondents infected with tuberculosis indicate that they were diagnosed with tuberculosis in the penitentiary system. It is important to examine the prisoners who had contact with prisoners infected with tuberculosis.

10,8% of the interviewed prisoners indicate that they had contact with a prisoner infected with tuberculosis in the cell for a certain period. It should be taken into consideration that the tuberculosis bacteria is easily destroyed in the sunlight and fresh air, but it lives longer and is easily spread in the closed environment and under poor ventilation. Bearing this in mind, in case of suspected tuberculosis, it is important to isolate a prisoner even before the diagnosis is confirmed. It is also important to examine the prisoners who were placed together with the prisoners who were suspiciously infected with tuberculosis.

Negative factors in the penitentiary system, including tobacco smoking, lack of fresh air and psycho-emotional state of prisoners, create precondition for secondary immunodeficiency and increases the risk of tuberculosis development among prisoners. Considering all this, presence of a prisoner together with a prisoner infected with tuberculosis in a closed space due to his/her delayed isolation may serve as a significant factor in the spread of tuberculosis. It is interesting that only 2,8% of the interviewed remand prisoners said they were or had been infected with tuberculosis, while the respective indicator among convicts was 8.6%.

In general, in light of the positive dynamics, special attention should be paid to screening for resistant forms of tuberculosis and monitoring of full treatment. As of 2016, 4 new cases of resistant tuberculosis were registered; 6 new cases were reported in the 5 months of 2017. This requires special attention due to the growing number of multidrug resistant (MDR) tuberculosis and extensively drug-resistant (XDR) tuberculosis in the overall population.

Prisoners infected with tuberculosis are treated in Penitentiary Facility N19, which was rehabilitated in 2013. Prisoners infected with sensitive and resistant forms of tuberculosis are isolated from each other and are treated in relevant departments. Along with treatment, systematic control is carried out to detect possible side effects and complications. Patients are provided with a special diet. The medicines of new generation - Bedaquiline and Linezolid have been used for treating the complicated forms of tuberculosis from 2015, like in the public healthcare system.

Like the absolute majority of the world's population, spread of HIV/AIDS in Georgia is higher in the penitentiary system than in the overall population. From 2014 to May 2017, 24 114 screenings for HIV/AIDS were carried out in the Penitentiary Facilities. 60.3% of respondents confirmed that such screening were conducted for them.

According to the current data, the HIV/AIDS incidence rate is decreasing in the penitentiary system: 34 new cases were reported in 2014, which is 0.33% of the total number of prisoners; 18 new cases were identified in 2015, 0.18% of the total number of prisoners; 15 new cases were reported in 2016, 0.16% of the total number of prisoners; 5 new cases were reported from January to June 2017, 0.05% of the total number of prisoners.

In May 2017, there were 77 prisoners infected with HIV/AIDS in the penitentiary system, 70 of them were undergoing antiretroviral treatment. According to the data of 2016, the HIV/AIDS incidence rate in the overall population was 0.02% (719 patients) and the prevalence rate was 0.16% - 5877 patients.[71]

According to the data of the World Health Organization, Georgia is among the countries with the highest prevalence of hepatitis C. According to the 2002 survey, prevalence of hepatitis C was 6,7% in Tbilisi. In 2015, the hepatitis C antibody tests of 7.1% of the 6012 respondents of the population-based survey of the National Center for Disease Control of Georgia and the US Centers for Disease Control were positive.[72] According to the national statistics, 2 647 cases of hepatitis C were registered in Georgia in 2014.

It has been proved that drug injectors are at higher risk of being infected with hepatitis C. According to the Behavioral Surveillance Survey (BSS) conducted in 2014-2015, 66.2% of drug injectors were infected with hepatitis C.[73]

The rate of screening for hepatitis B and hepatitis C has been quite high in the penitentiary system in recent years; 6618 inmates were screened in 2016. According to the statistical data of the Ministry of Corrections of Georgia, the number of prisoners infected with viruses of hepatitis was variable in 2016 - varied between 4.6% and 13.8% of the total number of prisoners.[74] Such an inconsistency in the prevalence of this disease may be related to the mobility of prisoners or shortcomings in the statistical data.

22.7% of the interviewed prisoners (223 prisoners) noted that they had chronic hepatitis C. The respective indicator was 9.1% among female prisoners and 25.5% - among men. In the semi-open and closed establishments, these indicators were 25.9% and 20.7% respectively. As for the age groups, the

[71] Stvilia K, Tsertsvadze T, Sharvadze L, Aladashvili M, del Rio C,Kuniholm MH and Nelson KE. Prevalence of Hepatitis C, HIV, and Risk Behaviors for Blood-Borne Infections: A Population-based Survey of the Adult Population of T'bilisi, Republic of Georgia. J Urban Health. 2006 Mar; 83(2):289 - 298.

[72] Government's decree N1704 of 18 August 2016 on approving the strategy for elimination of hepatitis C in Georgia in 2016-2020.

[73] Government's decree N1704 of 18 August 2016 on approving the strategy for elimination of hepatitis C in Georgia in 2016-2020.

[74] Annual Statistical Report of the Ministry of Corrections of Georgia, 2016
http://www.moc.gov.ge/images/temp/2017/06/02/d4a8c18689d1447d239ff30b91c5213c.pdf

disease is most common among prisoners aged between 35 and 50. 33.3% of them said they were infected with hepatitis C.

64.7% of the interviewed prisoners were screened for hepatitis C in the penitentiary system. 54% of prisoners infected with hepatitis C indicate that they were diagnosed in the Penitentiary Facility and 43.1% had been diagnosed before being placed in the institution. 10.3% of the latter have not applied to a doctor for screening; 8.2% applied to a doctor, but they were not screened.

The penitentiary health care system enjoys all services provided by the hepatitis C state programme. The services in the penitentiary system are equivalent to the programme of public healthcare system and all examinations, treatment tactics and medicines are similar to the standards in the civil sector. There are rooms for issuing drugs for the treatment of hepatitis C in the Penitentiary Facilities. The rooms are equipped with surveillance cameras, which record the process of receiving antiviral drugs by patients. Patients get a weekly supply of Ribavirin in the room. The process is controlled by a specially trained nurse. The decision on involving patients in the treatment is made by a commission in charge of involving patients in the sub-component of the hepatitis C treatment.

The second stage of the hepatitis C elimination programme started in October 2016, which will gradually involve all prisoners. The number of prisoners involved in the treatment varied from 476 to 633 in 2016 and from 148 to 329 in the 5 months of 2017. Like the public healthcare system, it has become possible to treat prisoners infected with hepatitis C with new generation drug Soposbuvir from August 2015 and with Harvon from 2016. According to the survey, 26.1% of patients infected with hepatitis C had completed the course of treatment and 22.3% were being treated at the time of the survey.

According to the data of 2015 and the first half of 2017, the frequency of the spread of intestinal infections did not exceed the civil sector indicators (0.75% of the population were infected in 2016). This was proved by the answers of 86.7% of the interviewed prisoners, who said that they did not have information about cases of collective food poisoning during their stay in the Penitentiary Facility.

However, like in every institution having a centralized food system, there is a risk of intestinal infections in the Penitentiary Facilities too. Such cases were reported in July[75] and August[76] 2016, when instead of usual 4-7 cases, the incidence of the infection exceeded 5-10 times the norm. In such a situation, the health care system of the Penitentiary Facility should be attentive and should timely respond to each case of the disease, determine the source of infection and if necessary, isolate prisoners and take appropriate sanitary-epidemiological measures.

[75] http://moc.gov.ge/images/temp/2016/09/07/4c4c674d305b79db0b7f084794a6a23b.pdf pg. 40
[76] http://moc.gov.ge/images/temp/2016/10/06/118430486e74db31415a3dd3aedf6b46.pdf pg. 37

The spread of sexually transmitted diseases is common in the penitentiary system. A survey conducted in Portuguese prisons showed that 6% of prisoners were infected with syphilis.[77] According to the survey carried out in the United States, 5.3% of female prisoners and 2.7% of male prisoners were diagnosed with the abovementioned disease.[78]

According to the data posted on the website of the Ministry of Corrections of Georgia, the incidence of sexually transmitted diseases in the penitentiary system was almost ten times as much as the incidence in the civil sector in 2017 (according to the National Statistics Office of Georgia, the incidence of sexually transmitted diseases was 61.1% across Georgia).

Considering that only 524 examinations were conducted to identify sexually transmitted diseases in the 6 months of 2017, it is necessary to take additional measures in order to estimate the actual spread of the acute and latent forms of this disease in the penitentiary system. Special attention should be paid to the diagnostics of blood-borne infections (HIV, hepatitis B and hepatitis C).

In almost every European country, these methods of screening are voluntary. The specificity of the country and needs of public health should also be considered. The medical personnel of the penitentiary system should provide comprehensive information to prisoners about the progress and complications of diseases. At the same time, they should do their best to make more prisoners interested in screening for these diseases.

Recommendations to the Minister of Corrections:

- **Place all prisoners infected with tuberculosis in the Tuberculosis Treatment and Rehabilitation Center for the purpose of proper management of the disease**
- **In case of detection of contagious infectious diseases, ensure timely isolation of the patient, disinfection of the cell and examination of all persons who had been in contact with the source of the infection in order to prevent the spread of the infection**
- **Ensure availability of information about preventive health care for prisoners through meetings and information brochures**
- **Encourage prisoners to undergo screening for Communicable Diseases though raising their awareness.**
- **Provide prisoners placed in penitentiary facilities with the screening of noncommunicable diseases in accordance with the Order №31 (22 April 2015) of the Minister of Corrections**

[77] Seroepidemiological survey of transmissible infectious diseases in a Portuguese prison establishment. Braz J Infect Dis vol.15 no.3 May/June 2011 *https://www.sciencedirect.com/science/article/pii/S141386701170188X, accessed on June 22, 2017*

[78] Centers for Disease Control and Prevention. Sexually transmitted disease surveillance 2004. US Department of Health and Human Services, Atlanta, GA. 2005.

4.5.3. Mental health services, suicide, self-injury

4.5.3.1. Mental health services

Prisoners' mental health has been a major challenge in the penitentiary health care system for decades. Deprivation of liberty is naturally a massive psychological trauma for a person, which can promote mental disorder or its de-compensation. Early diagnostics and preventive approach, which is very important in the management and prevention of diseases, gains special importance for mental health care in the penitentiary system. The burden of mental and behavioral disorder is much heavier and the number of such patients is significantly higher in the penitentiary institutions than in the overall population.[79]

According to the official data of 2014-2017, the prevalence of mental and behavioral disorders in the penitentiary system of Georgia was characterized by a growing tendency and sharply exceeded the respective data of the civil sector. In 2015 the prevalence of mental and behavioral disorders was 2682.5 in overall population, while the respective indicator reached 9056.4 in the penitentiary system in the same period (see diagram N13). However, it should be noted that the increase in the prevalence of mental and behavioral disorders in the penitentiary system may be caused by the improvement of the statistical data collection system and comparison with the prevalence data of civil sector may not reflect the real situation, since identification of mental and behavioral disorders is a big challenge for public healthcare sistem.

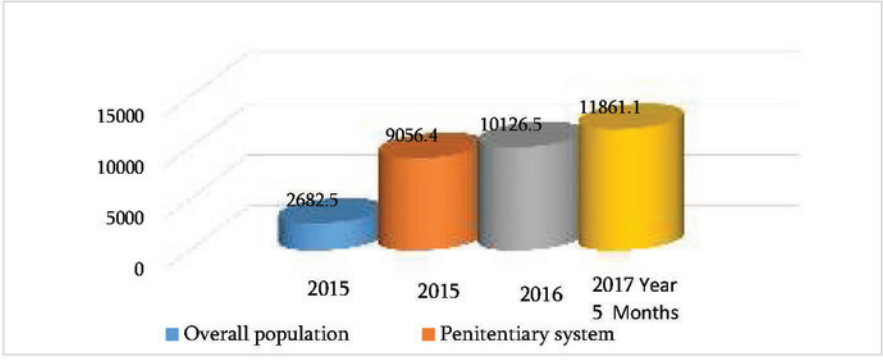

Diagram 13. Prevalence of mental and behavior disorders in civil sector and penitentiary system

[79] Torrey EF, Kennard AD, Eslinger D, Lamb R, Pavle J. More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States Treatment Advocacy Center. 2010. Available at: http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf, accessed on June 12, 2017.

According to the information received from the Medical Department of the Ministry of Corrections, the number of prisoners with mental and behavioral disorders in the Penitentiary Facilities was 1031 as of December 2015 and 1079 – as of December 2016.

Monitoring shows that the main challenge is timely identification of prisoners with mental and behavioral disorders, prevention of complications and adequate psychiatric care. Family doctors have no tools for objectively assessing the mental health of prisoners. In some cases, medical staff, despite the request of prisoners, do not refer patients to a psychiatrist as they believe that the request is ungrounded.

Mental health screening during primary medical examination of prisoners is superficial and is limited to three formal questions in the prisoner's outpatient medical record. The questions are as follows: Have you applied to a doctor-psychiatrist for assistance? Have you ever taken psychotropic medications? Have you ever attempted to self-inflict injury?

In order to provide adequate psychiatric assistance, it is necessary to introduce two-stage procedure for the identification of mental and behavioral disorders during the primary medical examination of prisoners in the Penitentiary Facilities: at the first stage, a questionnaire should be filled in and then analyzed, while at the second stage, in case of identification of risks through analyzing the questionnaires, patient should be sent to a doctor-psychiatrist for diagnostics and psychiatric assistance.

To date, authors have been provided with several versions of questionnaires for screening mental and behavioral disorders: Brief Jail Mental Health Screen (BJMHS); Correctional Mental Health Screen for Men (CMHS-M); Correctional Mental Health Screen for Women (CMHS-W); England Mental Health Screen (EMHS); Jail Screening Assessment Tool (JSAT); Referral Decision Scale (RDS).

For the objectives of the present study, the mental health condition of prisoners was assessed through sociological survey questionnaires. The Correctional Mental Health Screen (CM HS) questionnaire, developed by Ford JD, Trestman RL, Wiesbrock V, Zhang W in 2007, was used to develop questionnaires.[80] The mentioned questionnaire[81] is recognized as one of the most credible and sensitive tools of mental health screening in the penitentiary system.[82]

According to the results of the sociological survey, 26% of male prisoners and 27.7% of female prisoners interviewed in semi-open establishments need consultation with a doctor-psychiatrist. The respective

[80] Ford JD, Trestman RL, Wiesbrock V, Zhang W. Development and validation of a brief mental health screening instrument for newly incarcerated adults. Assessment 2007;14:279–299.

[81] The questionnaire takes into view sexual characteristics and consists of two parts – 12-point questionnaire for men (CMHS-M) and 8-point questionnaire for women (CMHS-W). The CMHS-M screening raises presumption of mental and behavioral disorders. CMHS-M. A consultation with a psychiatrist is recommended if a person has a positive response to 6 or more questions and in case of CMHS-W screening - 5 or more questions.

[82] Martin M. S., Colman I., Simpson A. I., McKenzie K.. Mental health screening tools in correctional institutions: A systematic review. BMC Psychiatry, 2013 13, 275.

indicators in closed institutions (includes a high-security prison as well) - are 35% and 38.3% respectively. According to the screening data, the respective figure is especially high among remand female prisoners - 46.8%. It should be noted that no difference was observed between remand and convicted male prisoners. According to the Special Preventive Group, adaptation may be more difficult for women at the initial stage of detention. The level of psychological distress in women before imprisonment is related to psychological traumas caused by sexual or domestic violence and their deeper emotions caused by separation from their children and family.[83] This group of prisoners needs more attention of medical personnel, namely psychologists and psychiatrists. In addition, women under 35 should be under special observation, as 41.7% of them are in need of doctor-psychiatrist's consultation.

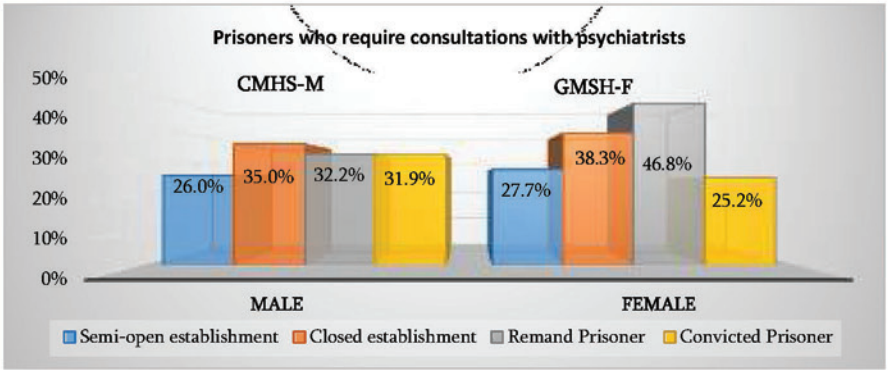

Diagram 14. Prisoners in need of a doctor-psychiatrist's consultation

It can be said on the basis of the monitoring results that mental health services intended for prisoners are limited to the following components: 1) psychiatrist's consultation and medicinal treatment in the penitentiary facility, 2) voluntary placement in the psychiatric unit of the medical facility for the remand and convicted prisoners, 3) involuntary or forced psychiatric assistance in the National Center for Mental Health (in the village of Kutiri). Each of these components are faulty, which makes it impossible to provide adequate psychiatric assistance to prisoners. Problems related to the above-mentioned two components will be discussed below, while the challenges related to involuntary or forced psychiatric assistance in the National Center for Mental Health was reviewed by the National Prevention Mechanism in its monitoring report of mental health facilities.[84] It should also be noted with regard to the placement of patients in the National Center for Mental Health that appropriate legal procedures are delayed in a number of cases (for 9 months in some cases). Therefore, it is

[83] Petrillo M. The Corston Report: A review of women with particular vulnerabilities in the criminal justice system. Probation Journal, vol. 54, 3: pp. 285-287, First Published Sep 1, 2007.

[84] Monitoring report of psychiatric institutions, 2015, pages 137-140, available at: http://www.ombudsman.ge/uploads/other/3/3695.pdf [accessed 04.01.2017]

important to review these legal procedures and practices in order to ensure timely inpatient psychiatric care for prisoners.

According to the official data of the Ministry of Corrections, the annual rate of utilization of psychiatric services (outpatient) was 10-11 000 on average in 2014-17, indicating the busy schedule of psychiatrists employed in the penitentiary system. The monitoring results indicate the lack of personnel needed to provide adequate psychiatric care in the penitentiary system. The number of psychiatrists employed in the system is insufficient. For example, only one psychiatrist was employed in Penitentiary Facility N 2, who had to consult 300 patients[85] on average per month. The situation was even worse in Penitentiary Facility N8; one psychiatrist was employed in the facility, while the number of prisoners was more than 2000.[86] As a result of examining the registers of consultations provided in the facility, it was found out that the visiting psychiatrists often serve 25-30 prisoners per day. Obviously, all this makes it impossible to ensure adequate quality of psychiatric services.

The low estimation of psychiatric services by the surveyed prisoners is probably caused by the very busy schedule of doctors and time deficit. In comparison with other employees, psychiatrists were most often rated as "bad" or "very bad" – by 29.6% and most rarely as "good" or "very good" – by 48.8%.

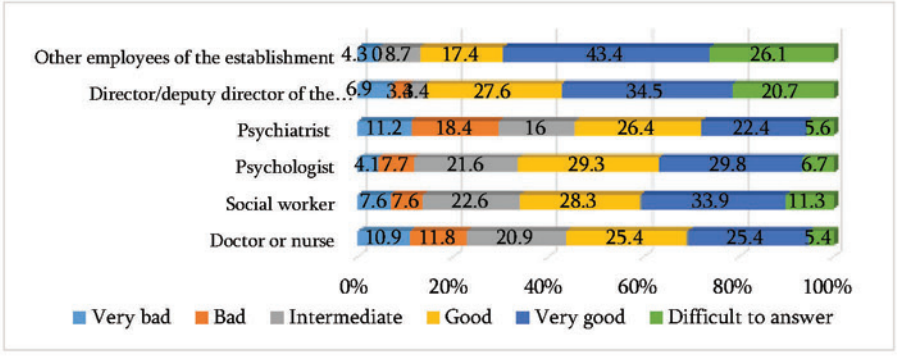

Diagram 15. Estimation of the quality of the service provided in case of emotional/psychological problems

The services provided by social workers and psychologists were rated higher, by 62.2% and 59.1% respondents respectively. Nevertheless, prisoners rarely apply to the employees of the penitentiary system or other prisoners for psychological assistance. 42.5% of the interviewed prisoners have never applied to anyone to address their psycho-emotional problems.

In order to provide psychiatric care within the penitentiary system, prisoners with mental disorders are transferred to the psychiatric unit of the medical facility for the remand and convicted prisoners

[85] As of April 2017, there were 1158 prisoners in Establishment N2.

[86] As of February 2017, there were 2324 prisoners in Establishment N8.

(N18).[87] It should also be noted that the latter is located in eastern Georgia (Tbilisi), which creates some problems in terms of geographical accessibility of the service. The rate of placement of prisoners with mental problems in the psychiatric unit was 425 in 2015, 592 - in 2016 and 205 - in the 6 months of 2017.[88]

Psychiatric assessment of a patient at the psychiatric unit of the medical facility for the remand and convicted prisoners is carried out by a psychiatrist upon the patient's admission. Psychiatric assessment and assistance are not of multidisciplinary (bio-psychosocial) nature and are limited to mental and psychological assessment and medicinal treatment. A social worker of the medical facility is not a member of the psychiatric team and does not participate in the assessment or management of a psychiatric case. The facility does not have material or professional resources for multidisciplinary psychiatric care, psychosocial intervention. The facility lacks qualified medical personnel.

Medicinal treatment of patients with acute, sub-acute and chronic mental disorders is voluntary in the psychiatric unit. According to the medical personnel, they do not force patients to take drugs; they achieve their consent through intensive communication. In their opinion, this method is effective and they do not need to use physical and chemical restraints. Consequently, there are no tools or specially trained medical personnel for physical restraint in the unit and no internal standard of physical restraint or isolation has been developed. Cases of coercion, physical abuse and physical restraint were denied by the surveyed patients as well. According to them, personnel talk with patients and advise them to take drugs, while in case of refusal, they leave them alone. During the interview, several patients said that they did not take or did not fully take the drugs prescribed by a psychiatrist. It should be noted that the patient's refusal to take drugs is not properly reflected in the medical records.

The psychiatric unit is properly supplied with medicines. It has been observed that during the selection of treatment scheme, advantage is given to neuroleptic drugs of older generation, while modern principles of psycho-pharmacotherapy are less considered. For example, in case of insomnia or irritation, simultaneous injection of Tysercin and Diazepam is systematically used, which is not in line with national[89] or international guidelines[90] for managing mental disorder, according to which, it is

[87] Opened on 1 July 2014.

[88] The rate of transfers to the National Center for Mental Health (Qutiri) included. The official statistics of the Ministry of Corrections are available at: http://moc.gov.ge/ka/statistika/yovelthviuri-angarishi [accessed on 05.01.2018]

[89] National recommendation (guideline) of clinical practice "Treatment and Management of Schizophrenia in Adults" http://www.moh.gov.ge/uploads/guidelines/2017/06/02/027a1faa4884f16b6046d141805f7e09.pdf, accessed on June 22, 2017

[90] Merck Manuals Professional Edition-Psychiatric Disorders –Behavioral Emergencies, see the link http://www.merckmanuals.com/professional/psychiatric-disorders/approach-to-the-patient-with-mental-symptoms/behavioral-emergencies. [accessed on 11.05.2018]
also, *Shorter Oxford*Textbook of *Psychiatry*/ M. *Gelder*, P. *Harrison,* P. Cowen, see the link https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxwc3lnZTIwMTF8Z3g6NDU1ODJmZDEyMzUxMDZlZA [accessed on 11.05.2018]

recommended to start medicinal therapy with monotherapy. In addition, advantage should be given to the drugs of new generation, mainly due to the low risk of side effects.[91]

Maintenance of inpatient medical records by the unit contains certain gaps. Records about doctors' concilium do not include relevant therapeutic plan or doctors' signatories. Clinical diagnosis is not always indicated on the cover of the medical record. Respective prescriptions are not always reflected alongside doctor's notes.

None of the programmes of constructive activities has been introduced in the psychiatric unit of the medical facility for the remand and convicted prisoners. Prisoner's day activities have not been planned; sports infrastructure has not been provided; there is no sport equipment; sport activities are not organized; the unit cannot provide adequate psychosocial rehabilitation of patients.

Given that there are problems with respect to achieving patient's consent to be involved in medicinal treatment in the psychiatric unit and that patients are not provided with appropriate psychosocial rehabilitation, it can be concluded that patients cannot receive psychiatric care based on bio-psychosocial approach. Management of a psychiatric case is practically impossible under similar conditions. According to the Special Preventive Group, only more intensive monitoring of patients by medical personnel and delivery of appropriate services in the field of physical diseases can be considered as a positive side of the placement of a patient in the psychiatric unit. In addition, it should be noted that placement of a patient with mental disorder in the psychiatric unit can strengthen the stigma.[92]

In a situation where no adequate psychiatric care is provided in the psychiatric unit, the transfer of prisoners with mental disorders from the Penitentiary Facility to the psychiatric unit can be seen as their isolation from other inmates. This opinion is further strengthened by the practice of solitary placement of a patient in the cell[93] of the psychiatric unit. 7 out of the 17 patients[94] interviewed by the Special Preventive Group were alone in the cell. They did not know the reason for the isolation and had the feeling of injustice. The patient's medical documentation did not indicate the reason for the solitary placement of the patient in the cell or contain further strategy of action. In addition, the physical environment in the cells failed to prevent self-injuries. The environment in the cells was negative, did not serve to provide positive therapeutic stimuli or improve the patient's mental health.

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[91] Rapid Tranquillisation Policy. 2016 http://www.hpft.nhs.uk/media/1561/foi-2362-26-10-2016-rapid-transquillisation-policy-attachment.pdf , accessed on June 20, 2017

[92] Mental Health and Prisons, p. 2, available in English at: http://www.who.int/mental_health/policy/mh_in_prison.pdf accessed on 05.01.2018.

[93] Every cell of the psychiatric unit is under electronic surveillance. According to medical staff, the psychiatrist does not have access to the footage of the electronic surveillance system.

[94] During the visit made on 17 January 2017, 36 patients were placed in the psychiatric unit.

According to the Special Preventive Group, it is a violation of the right to respect for personal and family life that the patients placed in the medical facility for the remand and convicted prisoners, including psychiatric patients, cannot enjoy long visits[95] or video visits due to the absence of appropriate infrastructure.

Considering all of the above, the survey results, according to which, prisoners' satisfaction[96] with the psychiatric unit of the medical facility for the remand and convicted prisoners is lower compared with other medical service providers[97], seem to be logical ("Satisfied" - 23.9%, "More satisfied than dissatisfied "- 7.5%).

After reviewing the mental health care services provided for prisoners, the Special Preventive Group concludes that on the other hand, the service provided is not adequate and on the other hand, the mental health care services lack several important components. First of all, it should be noted that significant shortcomings were identified in terms of identifying persons with mental health problems timely and referring them to the relevant service. Although some prisoners with mental health problems receive inpatient psychiatric care, majority of prisoners with mental health problems remain in the enitentiary establishments. After overcoming the difficult period and achieving stabilization, patients return to the Penitentiary Facilities, where they are not provided with support services or a favorable environment, which increases the risk of complication of mental health problems.

According to the Special Preventive Group, it is important to fully implement the package of mental health care services, including screening and timely referral, as well as inpatient and outpatient psychiatric care based on bio-psychosocial approach. Taking into consideration the peculiarities of the penitentiary system, penitentiary mental health care should be considered and developed in the context of national mental health policy documents. In terms of equivalence of services, it should be noted that the services available in the community are not available for prisoners. The Special Preventive Group believes that, through inter-agency coordination, certain services introduced into the community may be made available in the Penitentiary Facilities as well. It is also important to mobilize personnel in the Penitentiary Facilities in order to ensure that prisoners with mental health problems have access to appropriate psychosocial rehabilitation programmes. It is also advisable to attract service providers and encourage civic intervention.

[95] The list of establishments, where long-term visits may be carried out, does not include medical institutions, according to the "Rules for Long-Term Meeting of Convicts" approved by order N132 of the Minister of Corrections of Georgia on 22 July 2014 (establishments N18 and N19).

[96] For detailed information please see the sub-chapter section "General satisfaction of prisoners with medical services".

[97] The prisoners placed in the psychiatric unit of the medical facility for the remand and convicted persons for a certain period of time in 2014-2016.

Recommendations to the Minister of Corrections:

- Introduce a mental health screening tool and consider the appropriateness of the use of screening questionnaires - CMHS-M and CMHS-W
- Ensure that the number of patients consulted per day does not exceed 15, through increasing the number of regular psychiatrists or the visits of visiting psychiatrists
- Ensure that establishments maintain statistics on prisoners with mental health problems, identify their needs and develop psychosocial rehabilitation programmes
- Provide prisoners with psychological assistance, including through offering them involvement in the stress management programmes, in order to cope with the psycho-psychological problems caused by imprisonment
- Taking into consideration the busy schedule and obligations, increase the number of nurses and assistants in the psychiatric unit of the medical facility for the remand and convicted prisoners
- Supply the psychiatric unit of the medical facility for the remand and convicted prisoners with medications of new generation
- Ensure proper maintenance of medical documentation in the psychiatric unit of the medical facility for the remand and convicted prisoners so that the records of doctors' concilium include relevant therapeutic plan properly signed by doctors, clinical diagnosis is indicated on the first page of the medical record, doctor's prescription is indicated alongside doctor's notes according to the established rules, patient's refusal to take drugs is documented
- Introduce a programme of constructive activities, organize day activities, arrange sports infrastructure, provide sports equipment and organize sport activities in the psychiatric unit of the medical facility for the remand and convicted prisoners
- Introduce psychosocial rehabilitation programmes in the psychiatric unit of the medical facility for the remand and convicted prisoners
- Ensure that patients are isolated only in extreme cases for appropriately justified reasons, in a safe environment, under permanent observation of medical personnel and for the shortest period. Ensure that medical personnel develop further strategy of action in each case and document the results of the monitoring of the patient's health condition, as well as the measures taken, in the patient's medical record. If the patient is isolated, the physical environment in the cell should prevent the opportunity of self-infliction of injury
- Arrange the physical environment in such a way that the patient is not discouraged, but provided with positive therapeutic stimuli
- Provide appropriate infrastructure so that patients in the psychiatric unit of the medical facility for the remand and convicted prisoners can enjoy long visits and video visits
- Assess needs and allocate appropriate material-technical and human resources in 2018 in order to ensure psychosocial rehabilitation of persons with mental health problems in the Penitentiary Facility

- **Through interagency coordination, study the possibility of introducing the services available in the community in the Penitentiary Facilities and outline a relevant plan**
- **Develop a strategy to attract mental health care-related service providers and encourage civic intervention**

Recommendation to the Minister of Labour, Health and Social Affairs and the Minister of Corrections:

- **In order to ensure timely transfer of a patient to the National Center for Mental Health for the purpose of providing inpatient psychiatric assistance, through cooperation with the Prosecutor's Office of Georgia, revise the legal framework regulating the patients' forced treatment and involuntary psychiatric assistance, as well as the relevant practice, and initiate relevant legislative amendments**

4.5.3.2. Self-injury and suicide

Low social and family support, suicidal behavior in the past, mental disorder and emotional problems are common causes of suicide among prisoners. These causes are often accompanied by violence, bullying, conflicts among prisoners, poor prison conditions, etc. In spite of stress-factors, suicide is eventually caused by the sense of hopelessness.[98] Due to the complexity of the problem, prevention of self-injury and suicide in the Penitentiary Facility remains a challenge around the world.

According to the official statistics, the number of self-injuries in the penitentiary system has decreased in recent years (2375 - in 2015, 1936 – in 2016, 527 – in the 6 months of 2017). The rate of suicides and suicide attempts is as follows according to years:

	Suicide	Suicide attempt
2014	7	
2015	2	142
2016	5	146
First half of 2017	1	31

Table 7. The number of suicides and suicide attempts according to years

The penitentiary system is usually a home to vulnerable groups, characterized by increased suicidal and autoaggressive risks. The data of the survey conducted by the Special Preventive Group show that

[98] Preventing Suicide in Prison and Jails, World Health Organization, International Association for Suicide Prevention, 2007, p. 7, available in English at: http://www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf accessed on 08.01.2018

prisoners had been prone to self-injury and suicide even before being placed in the Penitentiary Facility.

Interestingly, the number of suicide attempts and self-injuries among the prisoners interviewed by the Special Preventive Group was higher before imprisonment than during imprisonment. After being placed in the penitentiary system, the number of self-injuries and suicide attempts decreased from 10.4% to 8.9% and from 5.7% to 4.8% respectively, while the frequency of suicidal thoughts increased from 8.8% to 11.1%. As for the female prisoners, the decreasing tendency is more obvious - from 10.4% to 3.9% and from 11.1% to 5.8%, while the frequency of suicidal thoughts increased from 11.7% to 13.1%.

The situation substantially changes by analyzing the data of the sociological survey according to the type of establishment. The above-mentioned positive tendency is mainly conditioned by the data of prisoners surveyed in semi-open establishments, which are characterized by the decreasing number of self-injuries and suicide attempts and the frequency of suicidal thoughts after imprisonment, while the number of self-injuries and suicide attempts remain the same and the frequency of suicidal thoughts increases significantly (by 4.2%) in the closed establishment (see diagram N16)

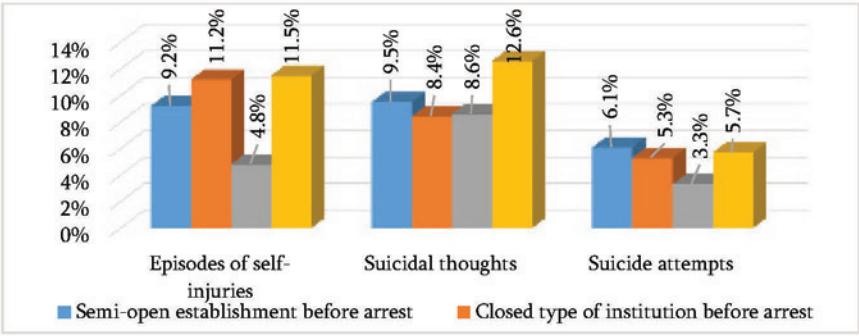

Diagram 16. Cases of autoaggression according to the type of establishment

According to the Special Preventive Group, firstly, it should noted that there is a high probability that the decreasing dynamics of self-injuries and suicide attempts in the semi-open establishments is conditioned by the practice of placing convicts in different types of institutions according to the risks. In other words, according to the practice, convicts expect to be taken to a closed establishment in case of self-injury or suicide attempts (pseudo-suicide), which somehow plays a deterrent role. On the other hand, the autoaggressive convicts, who turned out to be difficult to be managed in terms of security, were probably transferred to a closed establishment at the time of the sociological survey. The above-mentioned surely affected the results of the sociological survey. The opinion of the Special Preventive Group is further supported by the fact that suicidal thoughts are only slightly reduced in semi-open

establishments. This means that since prisoners usually do not express suicidal thoughts, no security measures are taken in response and prisoners remain in the semi-open establishment.

As for the number of suicidal thoughts in the closed establishment, according to the Special Preventive Group, increase in such thoughts after imprisonment is conditioned by the placement of autoaggressive prisoners as high-risk prisoners in the closed establishments on the one hand and by the strict regime and prison conditions in such facilities on the other hand. It is logical that prisoners placed in a cell with strict regime for 23 hours, where they lack any interesting activities, are more susceptible to suicidal thoughts.

It should be noted that the majority of male autoaggressive prisoners in the closed establishments named relations with prison staff as the main reason for autoaggression. In case of self-injury, this reason was named by 37.1% and in cases of suicidal thoughts and suicide attempts - by 20.0% and 27.3 % respectively. In semi-open establishments, the respective figures are much lower - 11.1%, 3.3% and 7.7% respectively.

The Public Defender noted in the parliamentary report 2015 that it is necessary to assess the mental health of prisoners who systematically demonstrate antisocial behavior and there is a suspicion that such behavior can be conditioned by their mental health condition. In addition, the Public Defender stressed that the approach to the patients prone to self-injuries and other behavioral disorders should be therapeutic and not punitive.[99]

The Public Defender of Georgia positively assessed the introduction of a suicide prevention programme in the penitentiary facilities. According to the results of the survey conducted by the Special Preventive Group, 4.8% of the 28% of the interviewed prisoners who had attempted to commit suicide were involved in the suicide prevention programme. 11% of respondents had suicidal thoughts[100] and 14.3% of them were involved in the programme. The situation of involvement of female prisoners in the suicide prevention programme deserves more attention. Despite the fact that suicide attempts and suicidal thoughts during imprisonment were indicated by 6.5% and 13% respectively, only 1.3% of the respondents were involved in the suicide prevention programme.

Taking into consideration the above statistical data, as well as the practice and the legal framework regulating suicide prevention programme, the Special Preventive Group considers that the programme needs further improvement.

The suicide prevention programme includes the following stages: 1) Descriptive risk assessment by a psychologist or a psychotherapist by determining the risk level and making a decision on the involvement in the programme; 2) Multi-assessment by determining the suicide risk level; 3)

[99] Public Defender's report 2015. http://ombudsman.ge/uploads/other/3/3789.pdf. Accessed on August 1, 2017

[100] 37.5% of prisoners, who have thought of suicide for the last three years after arrest, attempted to commit suicide.

Determination of multidisciplinary assistance plan by a multidisciplinary group; 4) Repeated multi-assessment by a multidisciplinary group. According to the Special Preventive Group, each stage requires analysis and further improvement.

In terms of suicide screening, the determination of the obligation of an operative officer to inform the local coordinator of the suicide prevention programme about the admission of a remand prisoner/convict, who had not been placed in the penitentiary system earlier, should be praised. The coordinator is obliged to meet the remand prisoner/convict no later than the next working day in order to make descriptive assessment of the suicide risk. Despite this, the periodic screening of suicide risks is still problematic. The normative act provides for periodic screening of prisoners who had been earlier involved in the suicide prevention programme, but were deprived of multidisciplinary assistance due to the low risk of suicide as a result of repeated multi-assessment. Similarly, no screening is provided as further control for inmates who were diagnosed with a low risk of suicide as a result of the descriptive assessment of suicide risk. This situation is problematic given that the level of suicide risk in the suicide group may increase over time and the absence of a periodic risk assessment system makes it impossible to timely identify increased and real risks of suicide.

The Special Preventive Group, taking into consideration the lack of psychologists and psychiatrists in the Penitentiary Facilities, considers that primary and periodic screening of suicide should be carried out by family doctors with a simple, sensitive tool. It is important to differ suicide screening from suicide risk assessment. Suicide risk screening is usually carried out with a sensitive tool and determines the absence or presence of suicide risk. This method, as a rule, does not provide information about the level of suicide risk, or about how momentary the risk is. In order to determine the level of risk as well as weather the risk is momentary, it is necessary to assess suicide risks with a more complex, refined tool than required during screening.[101] Exactly this is the function of the multidisciplinary team.[102] The team should assess the level of suicide risk and plan appropriate intervention by using an appropriate and detailed tool. After a predetermined time, the team must again assess the level of suicide risk, which would serve as the basis for planning further intervention or terminating it. Unfortunately, the current multi-assessment document approved by the Minister of Corrections is of a general character and obligates the multidisciplinary team to provide a brief description of suicide protection and risk factors, the practice of which is faulty. It is clear that it is necessary to elaborate a multi-assessment detailed tool based on the best practices and approve it by a relevant normative act. The Special Preventive Group expressed regret that the superficial assessment in practice leads to superficiality of

[101] Suicide Screening and Assessment, 2014, available at: http://www.sprc.org/sites/default/files/migrate/library/RS_suicide%20screening_91814%20final.pdf [accessed on12.02.2018]

[102] According to the suicide prevention programme approved by order N13 of the Minister of Corrections of Georgia on 11 February 2016, multi-assessment and further individual assistance are planned if a prisoner is at high or intermediate risk of committing suicide according to the descriptive assessment by a psychologist or a psychiatrist.

multidisciplinary assistance, which hinders the achievement of a positive result of the multidisciplinary assistance.

The Special Preventive Group believes that prisoners who are prone to self-injuries should be considered as a risk group and the measures aimed at preventing autoaggression should be taken in relation to them too. In any case, it is of vital importance to determine the causes of self-injuries and suicidal thoughts and to take appropriate measures to eliminate them. Planned interventions should include surveillance, social support and psychological assistance.[103]

The staff of the Penitentiary Facility should be cautious about the concept of "manipulative behavior". When the staff thinks that a prisoner is trying to manipulate the self-injury, they may not respond to it, as they think that it would be a response to the manipulation and an unjustified compromise. Regardless of the motive, the attempt to inflict serious self-injury or so-called pseudo-suicide may result in the death of a prisoner, whether or not it was originally intended.[104]

Considering all of the above, as well as the fact that it is problematic to define a suicide attempt, the Special Preventive Group considers that in order to increase the effectiveness of the suicide prevention programme, it is important self-injuries to be considered in close relation with suicide[105] and the programme to provide assistance to the prisoners prone to self-injuries as well. In addition, in the context of both self-injury and suicide prevention, special attention should be paid to timely identification and social support. Finally, the Special Preventive Group once again points out that the risks of self-injury and suicide can be reduced in the penitentiary system through making the environment in the penitentiary system healthier in general.

Recommendation to the Minister of Corrections:

- **Ensure the evidence-based assessment of the suicide prevention in order to further improve the programme**
- **Determine an obligation at the normative level and ensure that family doctors provide periodic suicide screening for all prisoners in the establishments**

[103] Preventing Suicide in Prison and Jails, World Health Organization, International Association for Suicide Prevention, 2007, p. 20, available in English at: see the link http://www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf [accessed on 11.05.2018].

[104] Ibid. p. 19

[105] According to the data of the survey conducted by the Special Preventive Group, 47.4% of prisoners, who had inflicted self-injuries before arrest, have thought about suicide. In case of self-injury during the last three years after arrest, the respective figure is 50.6%. 39.8% of prisoners, who had self-inflicted injuries before arrest, attempted to commit suicide and 35.3% of prisoners, who have self-inflicted injuries during the last 3 years after arrest, attempted to commit suicide.

- **Determine a relevant obligation at the normative level and ensure that prisoners described as prisoners with low suicide risk by multi-assessment or descriptive assessment are provided with regular suicide screening**
- **Develop a multi-assessment tool and approve it at the normative level**
- **Taking into account the peculiarities of the issue of self-injury, ensure that the suicide prevention programme is adapted and applied to the prisoners prone to self-injuries. At the initial stage, taking into consideration the existing resources, it is advisable to introduce an adaptive programme (in a pilot mode) in the high-risk establishments.**

5. HEALTH RISK FACTORS

5.1. Certain socio-demographic characteristics as risk-factors

The questionnaire of the sociological survey envisaged certain socio-demographic characteristics that might affect the health of prisoners both before and during imprisonment. It is known that various social determinants[106] have a substantial impact on human health. In addition, there is a close link between health and quality of life. According to the World Health Organization, health implies full physical, mental and social well-being and is not be limited only to the absence of a disease.[107]

943 prisoners, including 154 women and 790 men, were interviewed in the survey. 86.2% of prisoners are ethnically Georgian. Consequently, cultural context for this group of prisoners should not be a risk factor, while it may be additional stress-factor for other ethnic groups.

Approximately half of the interviewed prisoners (47.8%) are married, meaning that the other half of the prisoners may lack family support, which, along with other risk factors, may have a negative impact on the health and well-being of this group.

Human health is directly affected by poverty. Poverty worsens health, as it forces people to live in harmful conditions for health.[108] 14.8% of the interviewed prisoners said that their family income was not enough for proper nutrition before arrest, while 27.3% indicated that income was enough for buying food but not for buying clothes. 38,4% said that income was enough for food and clothes, but

[106] Fryers T, Melzer D, Jenkins R, Brugha T. The distribution of the common mental disorders: Social inequalities in Europe. Journal of Public Mental Health. 2005;1(14) pages: 1-12.

[107] Measuring Quality of Life, available in English at: http://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/ [accessed on 11.05.2018]

[108] Poverty and Health, available in English at: http://www.who.int/hdp/poverty/en/ [accessed on 11.05.2018]

they did not have financial resource to buy household items. 37% of prisoners were unemployed before arrest, which is almost three times the rate of unemployment in the country.[109]

According to the World Health Organization, the low level of education is directly related to poor health, more stress and low level of self-confidence.[110] More than half of the interviewed prisoners (55.6%) have high school diplomas, while the educational attainment of 10.4% is incomplete secondary education. 22.2% has received higher education. It should be noted that 0.4% of the interviewed prisoners are not able to read or write.

Lastly, it should be noted that 45.8% of the interviewed prisoners had been previously convicted. This fact should be taken into view both in terms of the length of exposure of this group to the risk factors of imprisonment and the complexity of their reintegration into society after leaving prison. Surveys show that in low and middle income countries, the situation of people in conflict with the law in the past is aggravated by poverty, social exclusion, restricted access to health care services, education or support system,[111] which is often followed by repeated detention. Such a situation makes this group a particularly vulnerable category. Therefore, it is important to provide effective reintegration programmes both inside and outside the penitentiary system.

In the sub-chapters below, the risk factors related to imprisonment will be mainly discussed; however, the risk factors, the target group's length of exposure to which is not limited only to imprisonment, will be indicated as well.

5.2. Use of drugs, psychotropic drugs, alcohol and tobacco, as risk factors

5.2.1. Use of drugs

According to the United Nations Office on Drugs and Crime (UNODC),[112] drugs were used at least once by 5 percent of adult population between the ages of 15 to 64 in 2014. Death caused by drugs in about one third to one half of cases was caused by overdose and was mainly related to the use of opiates. Most

[109] According to the data of the National Statistics Office of Georgia, the unemployment rate in Georgia was 11.8% in 2016. Available at: http://www.geostat.ge/?action=page&p_id=145&lang=geo [accessed on 03.01.2018]

[110] Health Impact Assessment (HIA), available in English at: http://www.who.int/hia/evidence/doh/en/ [accessed on 11.05.2018]

[111] Introductory Handbook on the Prevention of Recidivism and the Social Reintegration of Offenders, Criminal Justice Handbook Series, United Nations Office on Drugs and Crime, New York, 2012, available in English at: http://www.unodc.org/documents/justice-and-prison-reform/crimeprevention/Introductory_Handbook_on_the_Prevention_of_Recidivism_and_the_Social_Reintegration_of_Offenders.pdf accessed on 03.01.2018.

[112] UNODC.World Drug Report 2016. http://www.unodc.org/doc/wdr2016/WORLD_DRUG_REPORT_2016_web.pdf, accessed on June 1, 2017.

of the lethal cases caused by drug overdose most often occur immediately after imprisonment.[113] This indicates the necessity of providing assistance to drug addicts in the penitentiary system, involving replacement therapy, rehabilitation and educational programmes and provision of complete information about the risks associated with drug use.

Compared with the population, the use of psychoactive substances is higher among prisoners. Large part of prisoners had "rich practice" of the use of psychoactive substances before being placed in the penitentiary establishment and some of them have become addicted.[114]

About one-third of the interviewed prisoners - 30.5% (34.7% of men and 9.1% of women) indicate that they used drugs/psychoactive substances of various groups before being placed in the Penitentiary Facility. The main part of them, about three-quarters, were taking drugs of cannabis and opium groups (74.7% and 74.1% respectively), while 26.5% and 21.8% were taking homemade stimulants and Ecstasy respectively. The use of LSD, Amphetamine, Cocaine and Bio was confirmed in few cases.

It is an alarming fact that 30 percent of drug users used cannabis and especially the opium group drugs frequently (every day or several days a week) before being placed in the Penitentiary Facility. This figure is 7.2% among the prisoners using homemade stimulants; the use of psychoactive substances of other groups was episodic (see diagram N17).

Under the conditions of isolation, it is especially important to relieve the withdrawal pains of drug-addicted prisoners as much as possible. Currently, the methadone detoxification programme is an effective programme against withdrawal pains, which has been applied in the penitentiary system for years.[115]

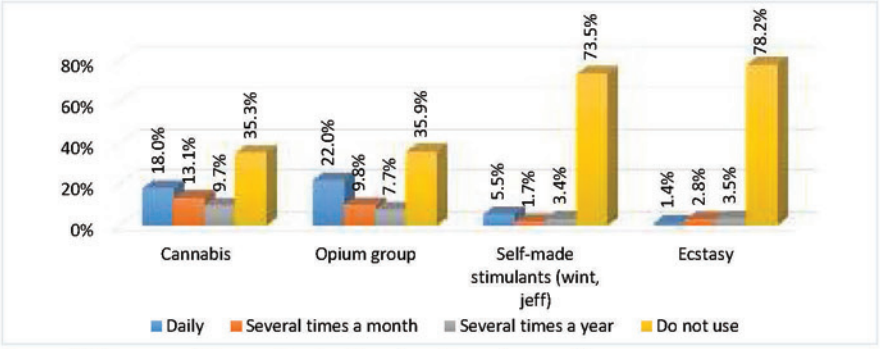

Diagram 17. Frequency of the use of various drugs by prisoners (anamnesis)

[113] WHO, Preventing Overdose Deaths in the Criminal Justice System (Copenhagen, 2014).

[114] Light, M., Grant, E. and Hopkins, K. (2013). 'Gender differences in substance misuse and mental health amongst prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners'. London: Ministry of Justice

[115] The methadone replacement programme is being implemented in Establishments N2 and N8.

More than 300 prisoners were enjoying the above-mentioned programme annually in 2014-2016. In 2017, there was a sharp increase in the number of prisoners involved in the programme (223 prisoners in 5 months). 8.1% of the prisoners interviewed by the Special Preventive Group were involved in the methadone replacement therapy during their stay in the penitentiary system. 1312 prisoners were treated for non-opioid drug addiction in 2015 and 1110 - in 2016.[116]

It is promising that through a joint order, the Minister of Corrections of Georgia and the Minister of Labour, Health and Social Affairs of Georgia approved the rule of implementation of replacement treatment programmes for the opioid addicts in prisons.[117] The order provide for the expansion of the programme[118] and determines the following types of replacement treatment: short-term and long-term detoxification, short-term and long-term replacement treatment. These programmes will fully take effect in 2018 and will be implemented in Penitentiary Facilities N2 and N8.

Atlantis, a psychosocial rehabilitation programme, has been implemented in the penitentiary system since 2016 with the purpose of overcoming drug addiction. Specially trained psychologists and social workers are working with convicts. Specially equipped spaces were arranged in Penitentiary Facilities N2, N5 and N6 for effective implementation of the programme. In addition, with the help of the Council of Europe, a methodical textbooks were prepared for the psychologists, therapists instructors and supporters involved in the programme. Atlantis has been successfully implemented in many European countries. The programme was launched in the Penitentiary Facilities of Georgia with the support of the Embassy of the Republic of Poland within the framework of "Human Rights in Prisons and Other Closed Institutions" - a joint project of the European Union and the Council of Europe.[119]

Atlantis is being implemented in Penitentiary Facilities N2 and N5. It should be noted that infrastructure for this rehabilitation programme was arranged but not functioning in Penitentiary Facility N6. The programme is a therapeutic model of the rehabilitation of convicts addicted to alcohol, drugs or other psychoactive substances (hereinafter beneficiary).[120]

Only 4.9% of the interviewed respondents were involved in Atlantis, which is a low number. According to the prisoners involved in the programme, they are provided with psychotherapy, art therapy and are involved in various educational activities, such as driving license course, hotel

[116] Statistical information on the website of the Ministry of Corrections.

[117] Joint order №92/01/26/n of the Minister of Corrections of Georgia and the Minister of Labour, Health and Social Affairs of Georgia, July 14, 2016.

[118] The modification and expansion of the programme was the recommendation of the Public Defender.

[119] Order N161 of the Minister of Corrections of Georgia on approval of instructions for the implementation of Atlantis, a psychosocial rehabilitation programme for convicts, in the Penitentiary Facility.

[120] Article 2 of the instructions for the implementation of Atlantis, a psychosocial rehabilitation programme for convicts, in the Penitentiary Facility.

management course, foreign language course, etc. A psychologist and a social worker are daily working with prisoners. According to prisoners, after involvement in the programme, they have enjoyed more freedom and avoided the prison routine, which has a positive impact on the quality of their life. Even though the prisoners' satisfaction with the programme is high and psychologists involved in the programme positively evaluate it, it was found out during the visit of the Special Preventive Group to Penitentiary Facility N2 that only 6 prisoners were enjoying the programme, even though the infrastructure and human resource of the establishment allowed simultaneous involvement of 12 prisoners in the programme. The staff could not properly explain the reason for the above-mentioned. It is also unclear why the programme was not implemented in Penitentiary Facility N6.

5.2.2. Use of psychotropic drugs

In the course of the survey, 38.6% of prisoners were taking psychotropic drugs; 16.9% of them had started taking drugs before arrest and 21.7% were prescribed drugs during imprisonment. If we also take into account the prisoners who had been prescribed psychotropic drugs, but were no longer taking them at the time of the survey, the number of which is 39.1% of the interviewed prisoners, we will get an alarming figure - 77.7% of prisoners were prescribed psychotropic drugs during their presence in the Penitentiary Facility.

A logical question is whether the psychotropic drugs are prescribed due to clinical necessities and how proportional their amount and frequency of use are, or whether multidisciplinary (biopsychosocial) assistance is replaced with more accessible but shorter and less effective medicinal treatment.

Psychotropic drugs have been widely used in the Penitentiary Facilities for years and in many cases, they were prescribed due to the prisoner's insisted request. Control of psychotropic drugs has been tightened over the past three years, which reduced the practice of prescribing psychotropic medication without clinical necessities. Nevertheless, addiction to psychotropic medicines is still a serious problem. The absence of psychotropic medicines often causes a prisoner's protest and self-injury.

5.2.3. Use of alcohol

Surveys show that excessive use of alcohol (daily or several days a week) is a problem of quite a lot of prisoners. The cases of excessive alcohol consumption and alcohol dependence are estimated between 18% and 30% among male prisoners and between 10 and 24% among female prisoners.[121]

The use of alcohol is prohibited in the Penitentiary Facilities. Accordingly, prisoners are protected from the side effects of excessive alcohol consumption, although significant part of prisoners were addicted

[121] Fazel S, Bains P, Doll H. Substance abuse and dependence in prisoners: a systematic review. Addiction, 2006, 101(2):181–191 Available at: https://www.ncbi.nlm.nih.gov/pubmed/16445547, accessed on August 5, 2017.

to alcohol or used strong alcohol drinks before being placed in the Penitentiary Facility and accordingly, the long-term side effects may be the cause of the worsening of prisoners' health.

According to the survey carried out by the Special Preventive Group, alcohol was used before arrest by 56.8% of the interviewed prisoners - 62.6% of male prisoners and 26.8% of female prisoners.

23.1% of prisoners excessively used strong drinks containing more than 40% of alcohol before arrest; 7.9% of them consumed such drinks daily and 15.2% - several times a week. Among the female prisoners, the respective indicator was 21.5%; 4.8% used such drinks daily and 16.7% - several times a week (see diagram N18).

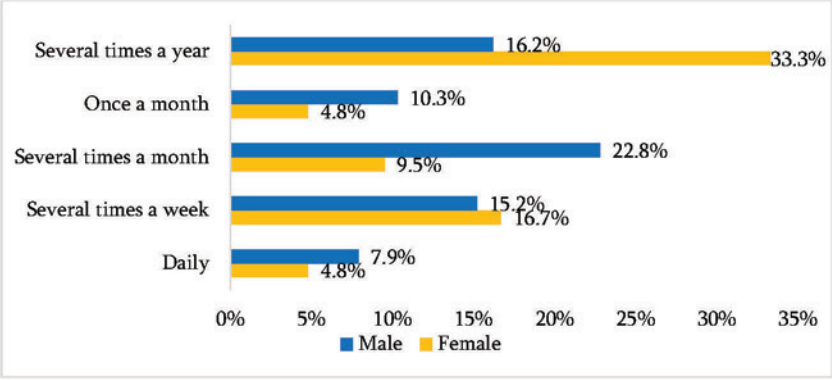

Diagram 18. The frequency of the use of drinks containing 40% of alcohol before being placed in the enitentiary Facilities

21.3% of the male prisoners drank excessive wine (including 4.9% daily and 16.4% several times a week). Among the female prisoners, this indicator was 14.6% (2.4% - daily and 12.2% - several times a week).

According to the Special Preventive Group, drug addiction, alcohol misuse and dependence on psychotropic drugs before arrest are serious problems for the Penitentiary Facilities. Since this problem cannot but affect the health of prisoners, it is necessary to reduce the harmful effects of substance abuse through appropriate medical assistance and psychosocial rehabilitation. It is important to increase the capabilities of the Atlantis programme and to introduce it in all Penitentiary Facilities.

5.2.4. Use of tobacco

Tobacco use is a complex phenomenon in the prison life. Tobacco use by prisoners cannot be explained only by their addiction to nicotine. The causes may include stress management, "struggle" against the boring prison life or the opportunity to achieve superiority in certain social situations. Full prohibition of smoking in similar situation can be perceived as a rough compulsion and may turn into an impossible

task. In addition, it may promote tobacco trade and smuggling. According to various data, the number of prisoners smoking tobacco varies between 4% and 91.8%, which significantly exceeds the frequency of tobacco use among the total population.[122]

The number of tobacco smokers among the prisoners surveyed by the Special Preventive Group was 75.3%. 79.1% of male and 55.6% of female inmates smoke tobacco. 6% of the respondents quit smoking after being placed in the Penitentiary Facility.

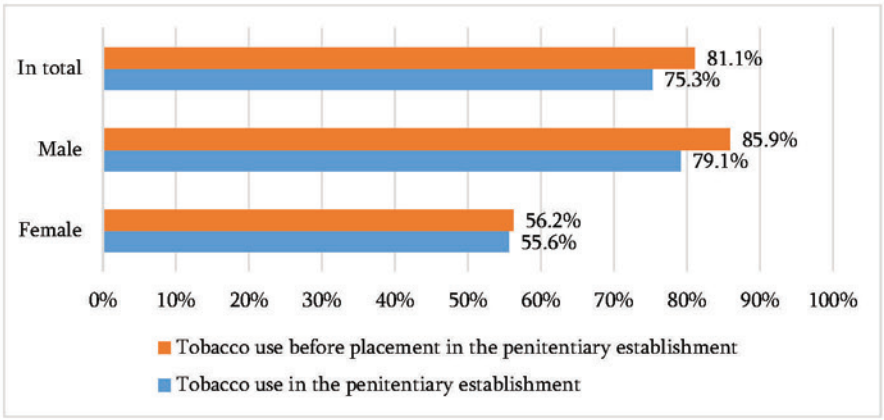

Diagram 19. The number of prisoners smoking tobacco

No statistically sound difference was identified betweeen the numbers of smokers according to the type of establishment. 76% of the prisoners of semi-open establishments and 74.7% of closed establishments smoke tobacco.

The use of tobacco is higher under 35 and between 35 and 50, 78.1% and 79.2% respectively, and this figure decreases to 61.2% among prisoners aged 51 and over.

13.8% of the interviewed prisoners who do not use tobacco are placed in the cell together with smokers, 43.1% of them are bothered by tobacco smoke. Smoking in the cell is very bothering for 8.9% of practically healthy prisoners and it is especially disturbing for prisoners with various diseases and their number varies between 3.9% and 28.4% according to the type of the disease (see table N8).

[122] Ritter C et al. Smoking in prisons: the need for effective and acceptable interventions. Journal of Public Health Policy, 2011, 32(1):32–45. Available at: https://link.springer.com/article/10.1057%2Fjphp.2010.47, accessed on July 22, 2017.

	Practicall y healthy	Minor health problem	Chronic disease	Serious health problem	I have a serious disease and need constant care
Very bothered	8.9%	16.8%	13.9%	28.4%	16.3%
More bothered than not bothered	8.3%	11.7%	12.4%	7.9%	3.3%
Neutral to tobacco smoke	10.9%	3.0%	3.3%	0.0%	14.2%
More not bothered than bothered	8.3%	1.4%	3.5%	5.6%	0.0%
Not bothered	25.8%	20.9%	18.6%	13.9%	20.0%
Prisoners in my cell do not smoke/ there are no prisoners in my cell	32.8%	40.0%	38.8%	44.2%	39.4%
Difficult to answer	5.1%	6.2%	9.7%	0.0%	6.7%
In total	100.0%	100.0%	100.0%	100.0%	100.0%

Table 8. How bothering the tobacco smoke is in the cell?

The main part of the smokers - 43% smoke one pack of cigarettes per day, 9.7% smoke less than 10 cigarettes per day, 22.6% smoke 10-20 cigarettes and 24.3% - more than one pack. 8.3% of smokers have been smoking for less than 5 years, 12.3% - 5 to 10 years, 27.9% - 10 to 20 years and 51.4% - more than 20 years.

No statistically sound connection has been found between tobacco use and health self-assessment. This may be caused by the fact that 75.3% of the interviewed prisoners are smokers and 31.9% of the interviewed prisoners regard themselves as practically healthy. In addition, it should also be taken into account that after some prisoners quit smoking after their health condition gets worse. In addition, the fact that smokers and non-smokers were not considered as separate strata in the survey methodology had a substantial effect on the survey results.

Due to the seriousness of the problem of tobacco use, it is important to isolate prisoners who do not smoke tobacco from smokers in case of their consent and to conduct a campaign about the negative effects of smoking on health and provide psychological assistance to the prisoners who want to give up smoking.[123]

Recommendation to the Minister of Corrections:

- **Enhance the capabilities of the Atlantis programme and introduce it in all Penitentiary Facilities**

[123] The issue of tobacco control in the penitentiary system should be considered in the context of the World Health Organization's Framework Convention on Tobacco Control, the State Strategy and Action Plan for Tobacco Control and the Law of Georgia on Tobacco Control.

- **In case of prisoner's consent, place the prisoners who do not smoke separately from the smokers**
- **Conduct information campaign about negative effect of tobacco on health**
- **Provide psychological assistance to the prisoners who want to quit smoking**

5.3. Prison food

Prisoners' nutritional standards are defined by the joint order[124] of the Minister of Corrections of Georgia and the Minister of Labour, Health and Social Affairs of Georgia, which was updated in July, 2017.[125] The order defines the nutrition norms, ingredient products and their energy content. The nutritional standards were developed in accordance with the type of establishment, prisoner's age, sex and health. Meals are served three times a day.

The Surveys carried out in recent years showed that inadequate nutrition and low physical activity of prisoners are important factors for prisoners' health.[126] The majority of the prisoners interviewed by the Special Preventive Group receive all the products included in the weekly menu, but some prisoners note that the amount and quality of food do not always meet the established norms. Among the interviewed prisoners who do not eat certain products, the most frequently mentioned reason is "I do not want to eat this food" – named by 44.1% to 71.0% of prisoners (see table N9).

	Do you eat the following products weekly			If you do not eat the listed products, what is the reason for this?							
	Yes	No	Refuse to answer	I do not want to take this food	I cannot afford it	The family does not supply me with it	It is not available in the shop	Is not adequate to my diet	It is of poor quality	It is not included in the menu	I find it difficult to answer
Fruit	70.2	25.8	4.0	12.8	11.0	14.2	2.1	0.7	2.6	46.8	9.7
Vegetables	84.5	15.5	0.0	48.8	2.6	1.8	2.8	4.4	17.2	8.1	14.3
Meat	86.9	12.4	0.7	46.6	2.2	2.9	0.7	2.2	25.6	1.9	16.3

[124] Joint order №88-№01-34/N signed by the Minister of Corrections of Georgia and Minister of Labour, Health and Social Affairs of Georgia on 13 August 2015 on the nutritional and sanitary-hygienic norms of remand and convicted persons.

[125] See the amendment at: https://matsne.gov.ge/ka/document/view/3711258 [accessed on 15.01.2018].

[126] Herbert K et al. Prevalence of risk factors for noncommunicable diseases in prison populations worldwide: a systematic review. The Lancet, 2012, 379(9830):1975–1982. Available at: http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60319-5.pdf, accessed September 2, 2017.

Fish	76.1	23.9	0.0	55.0	0.8	0.3	0.0	0.3	30.7	1.1	11.7
Dairy products	89.1	10.9	0.0	53.0	0.0	0.0	0.9	2.6	18.2	6.3	19.0
Bread products	92.9	6.5	0.6	44.1	0.0	0.0	0.0	22.6	10.6	0.0	22.7
Cereals	80.6	18.8	0.6	71.0	1.1	0.0	0.0	0.9	15.0	0.0	12.1

Table 9. The amount of food received by prisoners per week

Food quality was named as the second reason for refusing to eat meat and fish, by 25.6% and 30.7% respectively. The only exception is fruit, which is not received by 25.8% of the interviewed prisoners and the main reason is the absence of fruit on the menu. Other most common reasons are: "I cannot afford it," and "The family does not send me fruit". Prisoners say that they are served only with fruit compote.

Approximately 23% of the interviewed prisoners indicate the low quality of meat and fish ("Poor quality" and "More poor than good quality"). Approximately 20% of the interviewed prisoners indicate the low quality of vegetables. Low quality of other food products was indicated by prisoners between 5.7% and 16.6% (see table N10).

	It is of poor quality	It is more of poor quality than good quality	It is more of good quality than poor quality	Good quality	I find it difficult to answer the question
Fruit	1.7%	4.0%	15.3%	62.3%	16.6%
Vegetables	6.3%	13.5%	27.3%	43.7%	9.2%
Meat	9.6%	13.4%	27.2%	42.0%	7.8%
Fish	10.9%	12.5%	25.9%	42.6%	8.1%
Dairy products	7.1%	9.5%	24.8%	50.7%	7.8%
Bread products	6.4%	8.0%	22.0%	57.3%	6.3%
Cereals	4.7%	8.3%	24.8%	52.4%	9.8%

Table 10. The quality of food, according to prisoners

Prisoners' attitude towards the quality of food changes according to the type of establishment. The prisoners of semi-open establishments complain 50% less about the poor quality of food. The Penitentiary Facilities are supplied with food products from one and the same source. Thus, such a difference between the description of food quality by prisoners of semi-open and closed establishments may be conditioned by food preparation technology or delays in the delivery of food to the cells. According to some prisoners, hot meals are almost cold by the time they are served. the negative subjective mood of prisoners of closed establishments cannot be ruled out either.

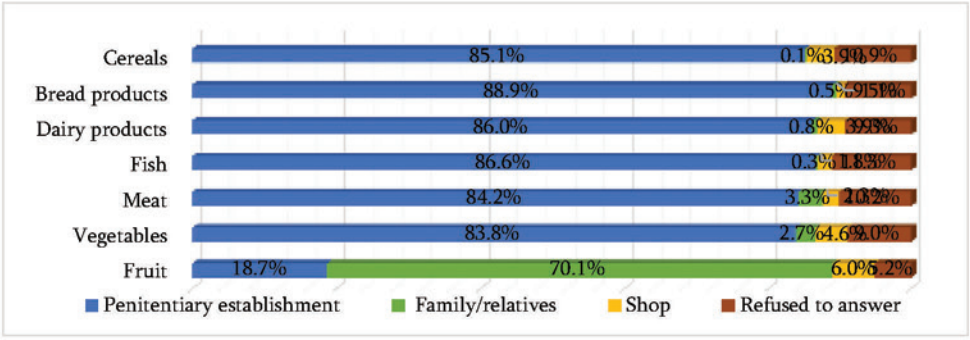

Diagram 20. The main sources of food supply

Majority of the interviewed prisoners name Penitentiary Facility as the main source of food supply. The indicators vary according to the type of food between 83% and 88% (see diagram N20)

The only exception is fruit, as 70.1% of prisoners named families or relatives as the source of fruit supply, 6% named the shop of the Penitentiary Facility and 18.7% named the Penitentiary Facility. Even though fruit (as well as jam and dried fruit) is envisaged in the joint order of the Minister of Corrections and the Minister of Labour, Health and Social Affairs, prisoners mainly receive only compote of dried fruit. The mentioned order allows such a substitution, which is problematic, according to the the Special Preventive Group. It is important to supply prisoners with fresh fruit in order to maintain their health.

It should be noted that prisoners can buy additional products at the shop of the Penitentiary Facility. Consequently, it is important to give prisoners the opportunity to buy products at prices that are not inadequately higher than the prices outside the penitentiary system.[127] As a result of the monitoring carried out by the Special Preventive Group, it was found out that the prices in the Penitentiary Facility are 10-20% higher than the prices outside the establishment, which is why prisoners express dissatisfaction.

The survey also checked prisoners's satisfaction with the amount of food they receive. Overall, 76%-88% of the interviewed prisoners said that the total amount of various products supplied by various sources was "sufficient" and "more or less sufficient" by (see diagram N21).

[127] European Prison Rules, Rule 35.1.

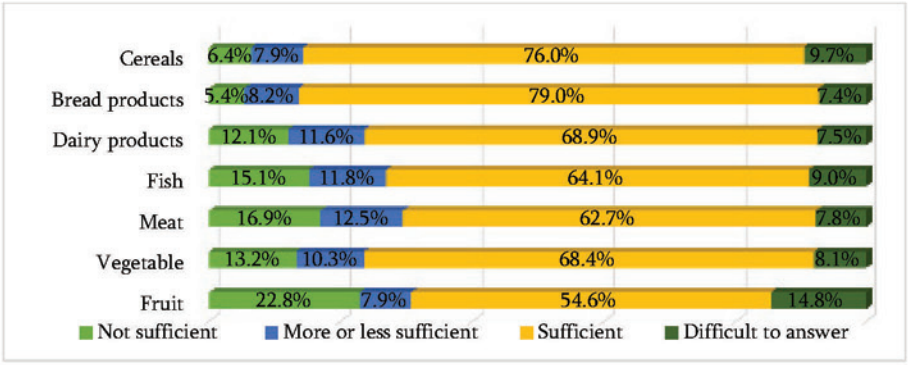

Diagram 21. How sufficient is the food you receive at the Penitentiary Facility?

Prisoners most often indicate the lack of fruit (22.8%), meat (16.9%) and fish (15.1%). The amounts of fresh vegetables are also small. The question – "Is there any product that you need but is unavailable at the establishment?" was positively answered by 17.9% of prisoners. Fruits and honey were most often named as such products.

The majority of prisoners noted that they had problems of digestive system, due to which they mostly tried not to eat oily or non-dietary food. Perhaps that is why 29.5% of the interviewed prisoners indicated that they needed dietary food, while majority of them (43.4%) said that they needed a diet intended for prisoners with gastrointestinal diseases.

The survey found correlation between the amount of food received at the establishment and the health condition. In a group of prisoners receiving enough amount of fruit, vegetables, meat and fish, 28.4% to 31.0% of respondents assessed their condition as "practically healthy", while in a group of prisoners who think that they do not receive enough amount of fruit, vegetables, meat and fish, 20.7% to 25.5% of respondents said they were "practically healthy". In the first group, prisoners between 6.1% and 6.8% complained about serious health problems and in the second group this indicator varied between 15.3% and 20.2% (see diagram N22).

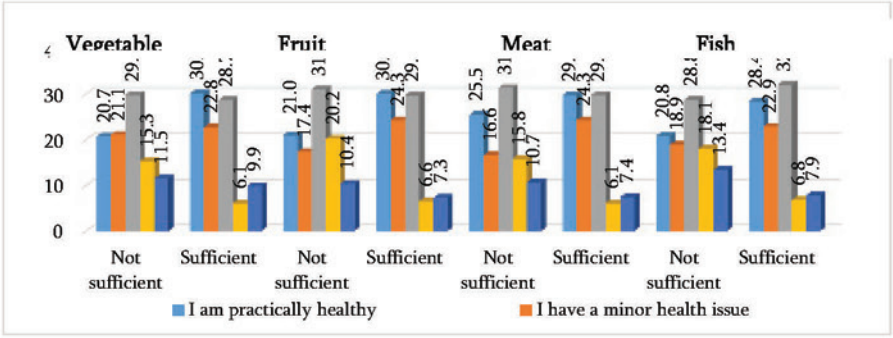

Diagram 22. The amount of food received at the Penitentiary Facility and prisoners' health condition

Correlation was also found between the amount of food received at the establishment and the prisoner's health self-assessment. In a group of prisoners who were receiving enough fruit, vegetables, meat and fish, the number of prisoners whose health condition relatively improved or remained the same during imprisonment according to prisoners' self-assessment, was persuasively higher than the number of prisoners whose health condition significantly worsened during imprisonment, which was almost one and a half times less (see diagram N11)

	Amount of fruit		Amount of vegetables		Amount of meat		Amount of fish		Amount of dairy products		Amount of bread products		Amount of cereals	
	Not sufficient	Sufficient	Not sufficient	Sufficient	Not sufficient	Sufficient	Not sufficient	Sufficient	Not sufficient	Sufficient	Not sufficient	Sufficient	Not sufficient	Sufficient
Sharply improved	1.3%	2.1%	1.9%	2.0%	2.9%	2.1%	2.8%	1.5%	1.9%	2.0%	2.0%	2.1%	2.0%	1.4%
Relatively improved	1.3%	4.5%	2.8%	4.0%	1.5%	4.3%	.9%	4.6%	1.9%	3.7%	2.0%	3.9%	4.1%	3.9%
Remained the same	34.6 %	45.3 %	29.0%	45.9 %	34.3 %	46.3 %	22.6 %	45.7 %	28.2 %	46.1 %	22.0 %	43.0 %	32.7 %	43.2 %
Relatively worsened	18.2 %	21.3 %	17.8%	19.2 %	20.4 %	18.8 %	23.6 %	20.4 %	22.3 %	19.0 %	30.0 %	18.5 %	16.3 %	20.5 %
Sharply worsened	44.7 %	26.3 %	47.7%	28.4 %	40.1 %	27.9 %	49.1 %	27.0 %	43.7 %	28.6 %	40.0 %	32.1 %	40.8 %	30.3 %
Difficult to answer	0%	.5%	.9%	.5%	.7%	.6%	.9%	.7%	1.9%	.5%	4.0%	.6%	4.1%	.7%

Table 11. The amount of food received at the establishment and the dynamics of prisoners' health condition

The impact of proper nutrition on prisoners' health was shown by international studies as well. For example, a study carried out in Spain showed that prisoners' body mass index and blood pressure were regulated by elaboration of a special diet for prisoners with cardiovascular diseases.[128]

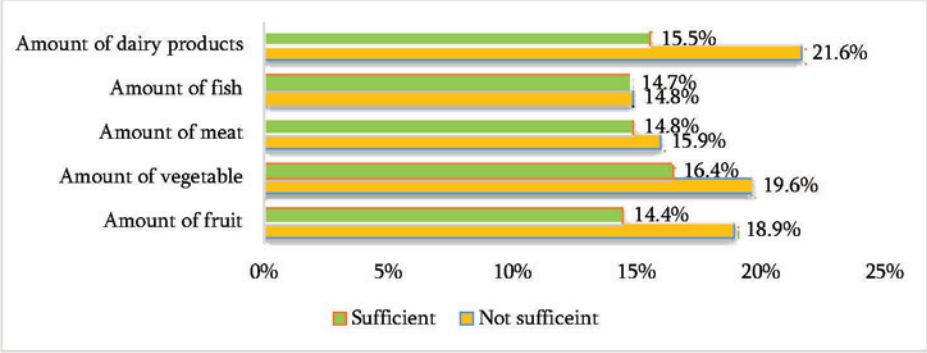

Diagram 23. Sufficiency of the amount of food received, according to prisoners

Some researchers say that a diet with poor microelements and vitamins has impact on the psychological condition of prisoners, in particular, it increases the number of episodes of anti-social behavior and violation of the regime.[129] There is more evidence that inadequate nutrition is linked to mental health and diet correction may have a positive effect on the patient's depressive condition.

Based on the above-mentioned, the Special Preventive Group considers it important to supply prisoners with a wide variety of healthy products. The seasonal specificity should also be considered.[130] It is necessary to observe proper sanitation and hygiene during preparation of food and to ensure that no harmful substances are included in the meals. Considering that the cost of nutrition of prisoners is still low[131] and the food supplied at the expense of the state is not diverse, it is essential to remove all

[128] Y Gil, JA Domínguez, E Martínez. Assessment of health benefits from a nutrition programme aimed at inmates with cardiovascular risk factors at Huelva prison. Rev Esp Sanid Penit 2011; 13: 75-83 Available at: http://scielo.isciii.es/pdf/sanipe/v13n3/en_02_original1.pdf, accessed on September 12, 2017.

[129] Gesch CB et al. Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behavior of young adult prisoners. Randomized, placebo-controlled trial. British Journal of Psychiatry, 2002, 181:22–28. Available at: http://bjp.rcpsych.org/content/181/1/22.long [accessed on 11.05.2018]

[130] Under Article 8 of the Nutrition Norms for remand and Convicted Persons (Annex 1) approved by joint order N88-N01-34/N of the Minister of Corrections and the Minister of Labour, Health and Social Affairs on 13 August 2015, season peculiarities should be considered in the prison menu. However, the study of the menu showed that the menus of different seasons were not essentially different from each other.

[131] According to the information provided by the Ministry of Corrections, as of September 2017, the food allowance per prisoner per day was GEL 3.995 (GEL 119.85 per month). According to the National Statistics Office of Georgia, the minimum standard as of September 2017 was GEL 168.8, 70% (GEL 118.16) out of which was food expense. Information about the minimum standard is available at: http://www.geostat.ge/?action=page&p_id=178&lang=geo [accessed on 16.01.2018]

restrictions within the process of sending food to prisoners in a care package unless some restrictions are strictly necessary in the interests of security. The norms regulating the process of sending food to prison should be revised and the types of food that can be sent should be clearly defined; the admissible amounts of certain food products and, in general, the monthly weight limit[132] of the care package and mail should be increased. At the same time, it is necessary to revise the prison food budget and allocate additional resources, taking into account the financial resources of the penitentiary system, in order to improve the nutrition of prisoners.

Recommendations to the Minister of Corrections:

- **Considering the financial resources allocated for the penitentiary system, increase the prison food budget in order to ensure that prisoners are supplied with diverse and healthy food**
- **Ensure that prisoners are supplied with fresh fruit at the expense of the state and that the amounts of fresh vegetables are increased**
- **Take all necessary measures within the framework of contractual relations with the private supply company to ensure proper supply of the shop. At the same time, ensure that products in the shop are available at affordable prices**
- **Make amendments to the provisions of the Penitentiary Facilities in order to remove all restrictions unless they are in the security interests in the process of sending food to prisoners in a care package. Clearly define the products allowed to be sent and increase the admissible amounts of certain products and, in general, the monthly weight limit of a care package and mail.**

5.3. Lack of information about health care and unaccessiblity of services as a risk factor

Patients have the right to receive full, objective, timely and comprehensible information about the available resources of medical service, as well as prices and forms of reimbursement.[133]

[132] The provisions of the establishments contain Annexes - The list of basic commodities, hygiene products, food and other articles that are allowed to be received, kept and used legally by prisoners (Annex 2), the list of food, basic commodities, hygiene products and other articles that are allowed to be received via mail, kept and used legally by prisoners (Annex 4). Annex 2 says that prisoners have the right to receive "food products: all kinds of fruits, except berries, grapes, melon and watermelon (no more than 5 kg). At the same time, the provisions indicate that by the permission of the Department's Director, prisoners have the right to receive additional food products. It is unknown what kind of food products apart from fruit are allowed to be sent to the Penitentiary Facility. It should also be noted that the provisions define the limit of the weight of a care package and a mailbox - 40 kg per month.

[133] Law on Patients' Rights, Article 18.

The survey showed that more than half of the interviewed prisoners have not received information or received incomplete information about the health care package, as well as the procedures of specific services, healthy lifestyle or disease prevention measures (see diagram N24).

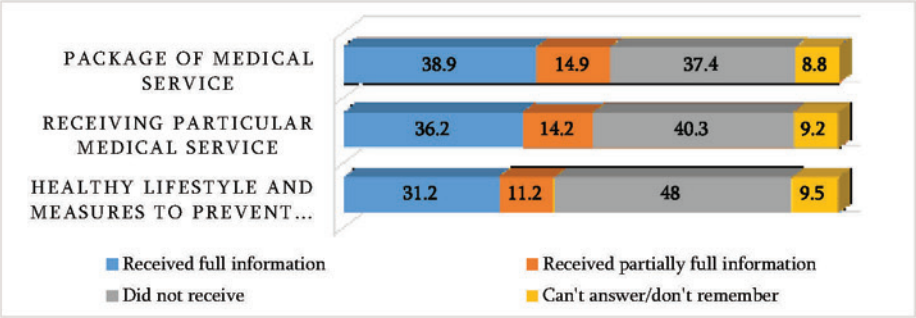

Diagram 24. Awareness

The survey results show that the level of awareness of health care services is higher among female prisoners (46.1%) than in male prisoners (37.5%). In addition, the level of awareness increases with age, which can be conditioned by the prisoners' experience; as health risks increase with age, the interest and awareness get respectively higher.[134] It should also be noted that the awareness of prisoners is higher in semi-open establishments (40.1%) than in closed establishments (25.7%), which may be conditioned by the fact that prisoners in semi-open establishments have more opportunities to communicate with medical personnel and other prisoners and therefore, the exchange of information, including about medical services, is more frequent.

The survey clearly shows that the quality of awareness of health care services has impact on prisoners' health self-assessment and its dynamics. The prisoners, who thought that they were fully informed about the health care services available in the penitentiary system, most often regarded themselves as practically healthy than those less or not informed (see diagram N25).

[134] 30.4% of 35-year-old prisoners have received full information on these packages of health care and the respective figure is 43.4% among prisoners aged over 50.

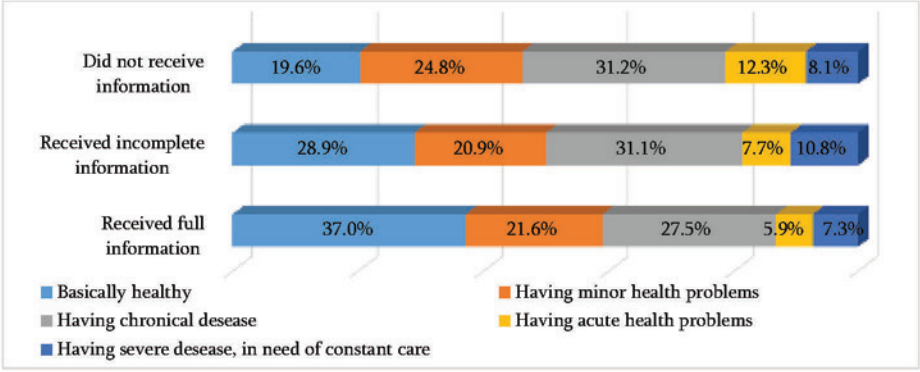

Diagram 25. The correlation between awareness and health self-assessment

Similar correlation was found between prisoners' awareness and self-assessment of the dynamics of their health. 45.2% of "uninformed" prisoners indicated that their health condition had sharply deteriorated during imprisonment, while the respective indicator was 24.5% among "informed" prisoners. And almost half of the prisoners indicated that their health condition had not changed during imprisonment (see diagram N26).

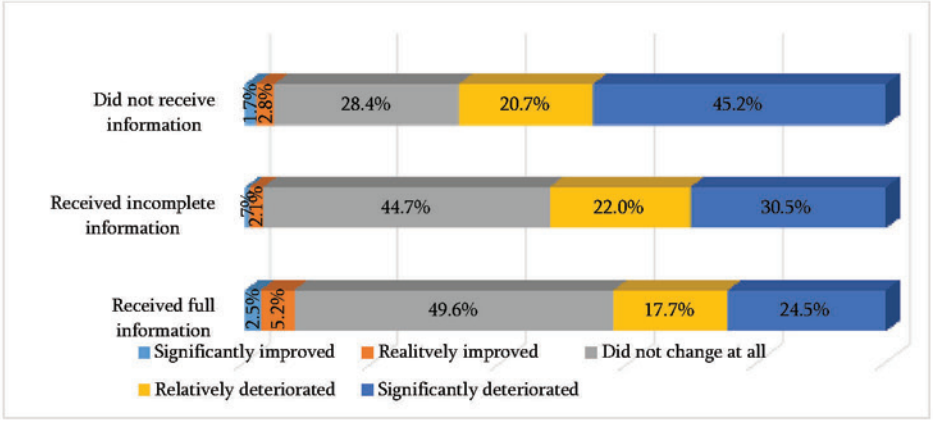

Diagram 26. The impact of full information about medical services on the dynamics of prisoners' health condition

Based on the above, it is clear that provision of information to prisoners is very important for health self-assessment. Both the communication with the personnel and the distribution of information booklets should be used for providing information to prisoners. The Medical Department of the Ministry of Corrections prepared information bulletins in 2015, but at the time of the visit to the Penitentiary Facilities, the number of the bulletins was limited.

Information on the above-mentioned medical services is received by prisoners mostly from medical and non-medical personnel of the Penitentiary Facility. As for other sources of information, only a

small number of prisoners receive information from other sources, such as other prisoners in the cell, other prisoners in the establishment, print materials, etc (see diagram N27).

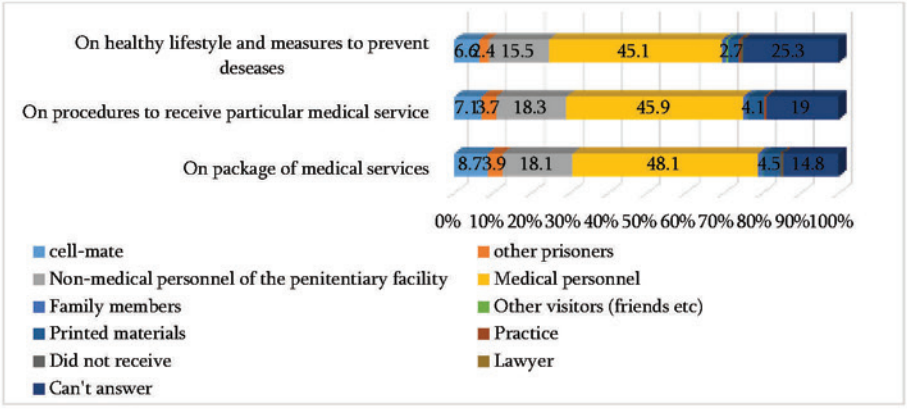

Diagram 27. Sources of information

The source of information affects the quality of information. Prisoners who cannot get enough information from the medical personnel regarding health care services are more unable to get full information from other sources. Consequently, the quality of information received is directly related to the source of information.

In accordance with Article 12 of the International Covenant on Economic, Social and Cultural Rights, the States Parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[135] According to the UN General Comment No 14, the right to health contains four elements: availability, accessibility, acceptability and quality of medical services.[136]

The European Committee for the Prevention of Torture[137] indicates that prisoners should have access to a doctor at any time, irrespective of their detention regime. The Public Defender of Georgia emphasized the problem of access to medical personnel in the parliamentary report 2016.[138]

The survey showed that the majority of the interviewed prisoners - 56.4% applied to a primary care physician for primary medical service, 28.7% applied to a dentist and 43.9% - to a nurse. Primary care was provided due to arterial hypertension[139] (15.3%), colds/viruses/high fever (11.3%), tooth

[135] UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 10 December 1966.

[136] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No 14, The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant) 11 August 2000.

[137] European Committee for the Prevention of Torture, par. 34, p. 61.

[138] Public Defender's parliamentary report 2016, see the link http://www.ombudsman.ge/uploads/other/4/4494.pdf [accessed on 12.04.2018]

[139] Increased blood pressure in aorta, including arteriolas.

pain/extraction (10.1%), headache (10.1%). The reasons for which the prisoners requested primary medical service are shown in diagram N28.

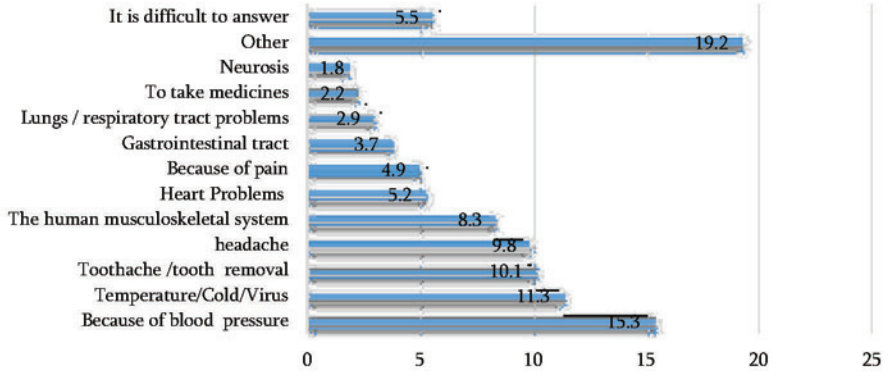

Diagram 28. The grounds for requesting primary medical service

As for the speed of the delivery of primary care, almost half of the interviewed prisoners (48%) noted that they were provided with such care within half an hour or less after their request; 5.4% - in an hour, 4% - in 2-3 hours. Delivery of primary medical service took 4 hours or longer according to less than 7% of the interviewed respondents. The diagram below clearly shows that more prisoners get primary medical service in half an hour or less time in semi-open establishments than in closed establishments.

		Type of establishment	
		Semi-open establishment	Closed establishment
How long did it take to get primary care when you last time requested it?	Half an hour or less	84.5%	59.3%
	An hour	5.2%	9.4%
	2-3 hours	2.0%	8.1%
	4-5 hours	-	2.0%
	6 hours or longer	2.4%	12.1%
	Difficult to answer	6.0%	.1%

Table 11. The speed of the delivery of primary care

Statistically sound relation was found between the prisoners' sex and the speed of the delivery of medical care. A higher percentage of female inmates received medical care in half an hour or less time than male inmates.[140] In addition, there was statistically sound relation between the prisoner's detention status and the speed of the delivery of primary medical care. In particular, the majority of convicted prisoners (73.3%) received this care in half an hour or less time, while the respective figure among remand prisoners was 58.2%.[141]

As for the relation between the **type of establishment** and the speed of primary care, the survey shows that primary care is provided to the vast majority of prisoners of semi-open establishments (84.5%) in half an hour or less, while the respective figure is 59.3% in the closed establishments. This means that there is statistically sound relation between these two categories.[142] The difference between the types of establishment may be related to the fact that in case of the need for a doctor, the prisoners of semi-open establishments apply to the medical personnel by themselves, as they can freely move on the territory of the establishment at daytime, while the prisoners of closed establishments have to apply to a prison officer first.

Prisoners, who need inpatient medical services, are served at medical Penitentiary Facilities N18 and N19 of the penitentiary department, as well as at civil hospitals. The medical facility (N18) for the convicted and remand prisoners provides diagnostic service and inpatient and outpatient treatment of prisoners.[143] Inpatient treatment for tuberculosis is provided at facility N19.[144]

Recommendation to the Minister of Corrections:

- **Provide information to prisoners about the health care services available in the Penitentiary Facilities, preventive health care and healthy lifestyle, through regular meetings with them and information campaigns, including distribution of information booklets.**

[140] Statistically sound relation observed between the sex of prisoners and the speed of medical assistance: $\chi 2(5)=23.713$ $p<0.05$

[141] Statistically sound relation observed between the prisoner's status and the speed of first aid: $\chi 2(5)=31.314$ $p<0.05$

[142] The relation between the type of establishment and the speed of primary care is statistically sound: $\chi 2(5)=52.647$ $p<0.05$

[143] The structural units of the medical unit of Establishment N18 are: reception; therapic division, resuscitation and anesthesiology division, surgery, division of psychiatry, division of tuberculosis and infectious diseases, long term care division, radiology division, laboratory, drugstore, dentist's room, sterilization block.

[144] Establishment N19 is designed for 540 beds, including 90 beds for MGB+ patients. The structural units of the medical unit of sstablishment N19 are: outpatient division of resistant tuberculosis; outpatient department of sensitive tuberculosis; inpatient division; intensive care division; laboratory; tuberculosis treatment and rehabilitation center provides evaluation, diagnosis and treatment of prisoners' health, outpatient and inpatient rehabilitation; qualified medical services in phthisiology; anti-tuberculosis treatment under DOTS and DOTS + Strategy.

5.4. Prison conditions

Deprivation of liberty is a very heavy punishment. Imprisonment leads to the restriction of rights by the court. Penitentiary authorities should not try to further aggravate the sentence imposed by the court with inhuman or unjustifiably strict treatment of prisoners. On the contrary, they should do their best to prevent the deterioration of physical and psychological condition of persons under their control.[145]

For the objectives of the survey, prison conditions include the kind of private space, where sanitary-hygienic conditions are observed; personal hygiene items are provided for each prisoner; prisoners have the opportunity to spend time in the open air; natural and artificial ventilation, heating and lighting systems properly function in the cells; prisoners' individual rehabilitation plans are elaborated; prisoners are provided with diverse daily activities and employment opportunities.

Even though the majority of prisoners positively evaluated the living conditions in the Penitentiary Facilities, this can be explained by the fact that prisoners' expectations regarding prison conditions may not be in compliance with the requirements of international human rights standards.

The monitoring conducted by the Special Preventive Group showed that conditions in some Penitentiary Facilities contradict the principle of normalization,[146] fail to protect prisoners' health or ensure respect for their private life. After analyzing the survey results, the Special Preventive Group concluded that closed space, separation of prisoners and restrictive environment have a negative impact on prisoners' health.

5.4.1. Physical environment and sanitary-hygienic situation

Inappropriate prison conditions may sometimes seen as inhuman and degrading treatment. "The living conditions in prisons shall resemble as closely as possible the normal living conditions outside prisons."[147] The living space of a prisoner shall prevent the deterioration of his/her health condition.

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[145] Andrew Coyle, A Human Rights Approach to Prison Management for the employees of the penitentiary system, available in Georgian at http://www.nplg.gov.ge/ [accessed on 23.01.18].

[146] The normalization principle: "Living conditions in prison should as closely as possible resemble the living conditions outside prison."

[147] Council of Europe, Recommendation Rec (2003)23 of the Committee of Ministers to member states on the management by prison administrations of life sentence and other long-term prisoners (Adopted by the Committee of Ministers on 9 October 2003 at the 855th meeting of the Ministers' Deputies), par 4. http://pjp-eu.coe.int/documents/3983922/6970334/CMRec+%282003%29+23+on+the+management+of+life+sentence+and+other+long+term+prisoners.pdf/bb16b837-7a88-4b12-b9e8-803c734a6117

Overcrowding of the penitentiary system remains a challenge in the country.[148] Significant problems in this direction include the practice of incorrect application of the limits of placement of prisoners in the Penitentiary Facilities and large shared (barrack type) living space in some facilities.

The practice of incorrect application of the limits of placement of prisoners in the Penitentiary Facilities leads to problems relating to the allocation of 4 sq.m of living space for each prisoner and the lack of space for various rehabilitation activities as well as recreational zones in some establishments, which prevents Penitentiary Facilities to implement its main function - rehabilitation of prisoners and their integration into society.

No private environment is provided in the large shared (barrack type)[149] living space in some facilities, smokers and non-smokers live in one and the same area, protection of sanitary-hygienic conditions is difficult and the danger of spreading infectious diseases is high. Additionally, this type of space leads to additional and significant security challenges, as there is a higher risk of conflicts between prisoners in the absence of private space.

The interviewed prisoners positively described the natural and artificial ventilations, sewerage system, heating, sanitary-hygienic conditions and dampness of the cells.[150] Despite the fact that a considerable percentage of the interviewed prisoners positively described the natural ventilation, artificial ventilation, sewerage and heating systems, according to the Special Preventive Group, Penitentiary Facilities have infrastructural problems, which have been mentioned by the Public Defender in a number of parliamentary reports that also included recommendations concerning the improvement of living conditions in the establishments.[151]

According to the information provided by the medical personnel of Penitentiary Facilities,[152] prisoners have lower back pain (called Symptom Neri), which is caused by the fact that they move less and sleep

[148] The number of prisoners exceeded limits in Establishments N2 and N15 in the last 4 months of 2016 and in Establishment N2 in the first 7 months of 2017.

[149] Establishments N14 and N17.

[150] Natural ventilation in cells was positively evaluated by 84.5% of prisoners, only 6% of respondents indicated that natural ventilation was inadequate. Artificial ventilation was positively evaluated by 65.8% of prisoners, and about 19% of respondents said it was inadequate; 5.3% of respondents said that there was no artificial ventilation in their cells. 89% of prisoners positively evaluated the heating of the cells. Only 4.3% indicated that it was inadequate. As for sewage, most respondents positively evaluated it (fully adequate - 83.2%). When asked if their cells were damp, the majority of respondents - 76.5% noted that their cells were not damp. General sanitary and hygienic conditions of the cells were positively evaluated by 79.5% of respondents. Most prisoners indicating unsatisfactory sanitary and hygienic conditions in the cells are placed in the closed establishments. 17.6% says that their cells were more or less damp; only small percentage of respondents (4.7%) said that their cells were very damp. The sanitary-hygienic situation in the cells was evaluated as unsatisfactory by 9.2% of respondents.

[151] For detailed information, see the Public Defender's parliamentary report 2016 http://www.ombudsman.ge/uploads/other/4/4494.pdf, pages 106-107.

[152] According to the information provided by the medical staff of Establishment N3.

in one and the same position on a narrow bed;[153] prisoners also suffer from gastrointestinal disorders caused by the lack of movement, poor nutrition and sleep; headache is also frequent, which is explained by the lack of air/oxygen in the cells; the personnel also say that there are frequent cases when prisoners have rashes that cannot be treated with medicines and that might be caused by the poor prison conditions and the lack of air in the cells.

Since prisoners of closed establishments do not spend more than an hour in the open air[154] and since there are natural and artificial ventilation problems in the cells, the Special Preventive Group believes that prisoners should have the opportunity to spend more time in the open air, and adequate natural and artificial ventilation systems should be provided in the cells.

The number of prisoners who regard themselves as practically healthy is higher among those who describe the sanitary-hygienic conditions of their cells as satisfactory compared with those living in unsatisfactory conditions.

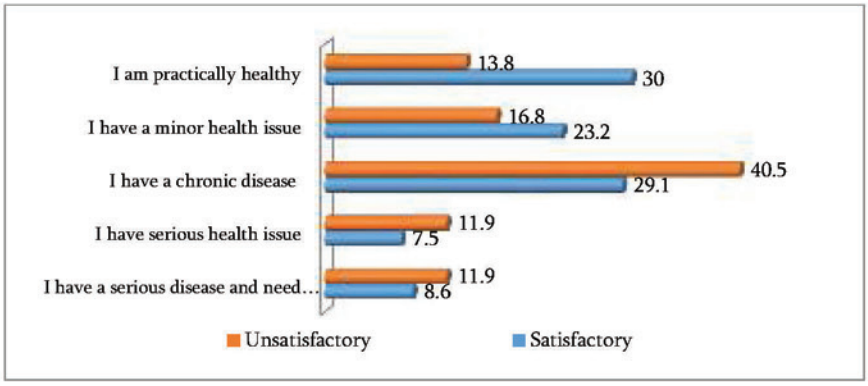

Diagram 292. Relation between prisoners' self-assessment and sanitary-hygienic situation in prison cells

Similar tendencies were observed in the prisoners' self-assessment of the dynamics of their health condition. 61,9% of prisoners who think that they live in unsatisfactory conditions indicate that their health condition deteriorated after arrest, while the respective figure is 47% among prisoners living in satisfactory conditions; malmost half of prisoners indicate that their health condition has not changed during imprisonment.

[153] Bed size - 63x189 cm.

[154] According to the Imprisonment Code, the remand and convicted persons shall have the right to daily spend at least an hour in the open air (enjoy the right to walk).

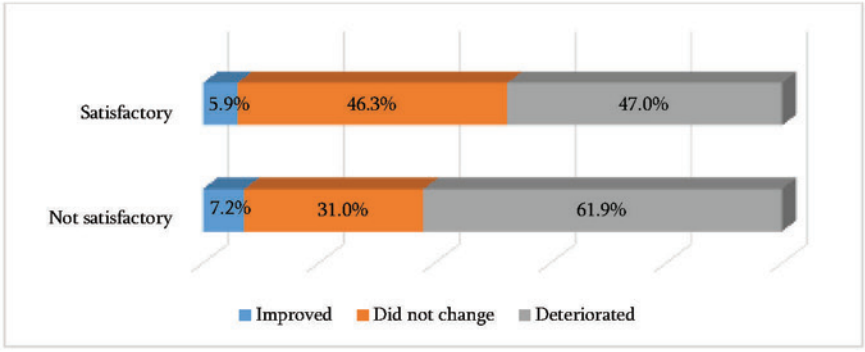

Diagram 303. Relation between prisoners' self-assessment, changes in their health condition and sanitary-hygienic situation in prison cells

Additionally, prisoners, who think that they live in unsatisfactory conditions, more frequently indicate that they suffer from various diseases.

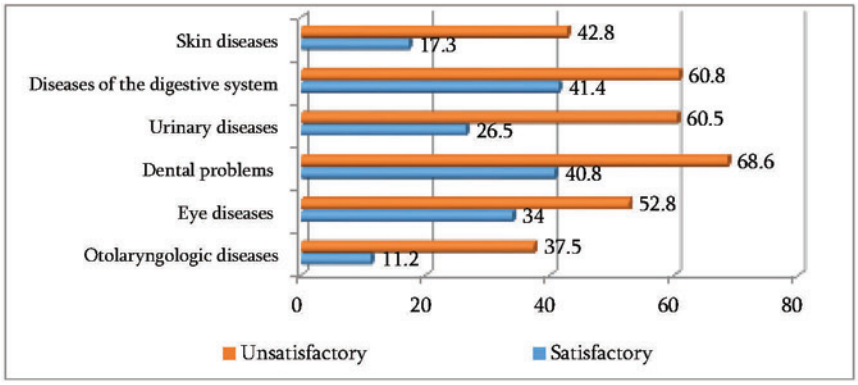

Diagram 31. Relation between sanitary-hygienic situation in the cells and spread of diseases

The existence of cockroaches (33.4%), bugs (6.8%) and mice (3.9%) in the Penitentiary Facilities remains problematic.[155] It should be noted that during the visit[156] made by the Special Preventive Group in the course of the survey, lice were detected in the psychiatric unit of Penitentiary Facility N18.

Prisoners differently estimate the frequency of disinfection, disinsection and deratization in the cells.[157] 15.8% of the interviewed prisoners say that their cells have not been disinfected, disinsected or

[155] Some prisoners mentioned other parasites as well (ant, mites, etc.), although their number does not reach even 1%.

[156] The visit was made to establishment N18 on 17-18 January 2017.

[157] It turned out that most common practice was disinfection: several times a month (indicated by 28.2% of prisoners); several times in the quarter (indicated by 24.8% of prisoners). Fewer respondents indicated other frequency of disinfection procedures (daily, several times in six months, several times a year or less frequently).

deratizated during their presence in the Penitentiary Facility and 11.2% say that they refused such procedures due to their very bad smell; as a rule, the procedures are carried out in the presence of prisoners, which has a negative effect on their health.

Personal hygiene products turned out to be available for the absolute majority of prisoners (between 82 and 98%).[158] The majority of prisoners (54.1%) are satisfied with their ability for maintaining personal hygiene and another 15.6% of prisoners are more satisfied than dissatisfied, while 17.3% are dissatisfied. 82% of respondents like the practice of providing new mattresses to prisoners upon their admission to the facility.[159]

Although quite a lot of prisoners evaluated the living conditions of Penitentiary Facilities as positive, it is important that the principle of normalization be maintained, which means that "living conditions in prisons shall resemble as closely as possible the normal living conditions outside prisons".[160]

5.4.2. Daily activities and rehabilitation

Every prisoner shall be provided with the opportunity of at least one hour of exercise every day in the open air, if the weather permits,[161] while when the weather is inclement alternative arrangements shall be made to allow prisoners to exercise.[162]

The majority of respondents (60.2%) spend time in the open air outside cells every day. 17.2% of respondents do not use this right at all.[163] 88.3% of prisoners placed in semi-open establishments spend time in the open air every day and 16.4% - several days a week. Prisoners of closed facilities use this right almost 50% less (42.6% and 6.9%). It is worrisome that about a quarter of prisoners interviewed in the closed facilities (27.1%) do not use this right at all.

The time spent in the open air outside cells lasts about an hour for the majority of the interviewed prisoners (58%), while approximately 40% of prisoners spent one to eight hours in the open air. One

[158] Soap, toothbrush, toothpaste, toilet paper, single-use soap, hygienic pads (for women), individual or shared electric shavers were available only for part of prisoners (13.9% and 28.6%).

[159] 10.8 % evaluated it negatively.

[160] Council of Europe, Recommendation Rec (2003)23 of the Committee of Ministers to member states on the management by prison administrations of life sentence and other long -term prisoners (Adopted by the Committee of Ministers on 9 October 2003 at the 855th meeting of the Ministers' Deputies), par 4 .http://pjp eu.coe.int/documents/3983922/6970334/CMRec+%282003%29+23+on+the+management+of+life+sentence+and+other+long+term+prisoners.pdf/bb16b837-7a88-4b12-b9e8-803c734a6117

[161] European Prison Rules, Rule 27.1

[162] Ibid. Rule 27.2

[163] 12.8% of the interviewed prisoners spend time in the open air several times a week, 2.4% - once a week, 3.5% - several times a month, 2.4% - once a month and 0.5% - very rarely.

fifth (20%) of prisoners of semi-open establishments spend about an hour in the open air, while the same time is spent outside cells by the majority of respondents of the closed establishment (89.7%).[164]

The lack of presence in the open air has a negative effect on physical and mental health of prisoners. The survey showed that 32.1% of prisoners, who daily spend time in the open air, say they are practically healthy. Prisoners of the same group more rarely indicate severe and chronic diseases. In addition, they are less prone to self-injuries, suicidal thoughts and suicide attempts.

The survey shows that there are several reasons of why prisoners do not spend time in the open air. In particular, they are afraid that an illegal thing may be planted on them during their absence in the cell (15.4%); they are offered to spend time in the open air during inconvenient hours - early in the morning or late at night (14.6%); bad weather/the cold (9.7%), lack of motivation (9,2%), they like being alone in the cell (9%), poor health (5.5%), they are not taken for a walk, if other prisoners in the cell refuse to go (3%), regime (day schedule) (2.7%), etc. The reasons for which prisoners refrain from leaving their cells were indicated in the 2016 parliamentary report[165] by the Public Defender of Georgia as well.

The sleeping hours of the majority of prisoners are optimal. A high number of respondents - 43.2% - sleep 8 hours or more at night, up to 37% sleep 5-8 hours, 17.7% of respondents say that they sleep only 1-4 hours.

The survey shows that 39.5% of prisoners, who sleep on average 8 hours or more, believe that they are practically healthy. The prisoners' health self-assessment decreases if the number of sleeping hours decreases. 23.4% of prisoners, who sleep on average 5-8 hours a day, think that they are practically healthy, while the respective figure is only 11.9% among prisoners who sleep 1-4 hours.

[164] Less than 5% of prisoners interviewed in the closed facility (the convicts involved in prison labour) have the right to spend more than 1 to 8 hours in the open air outside the cell.

[165] http://www.ombudsman.ge/uploads/other/4/4494.pdf , pages 108–109.

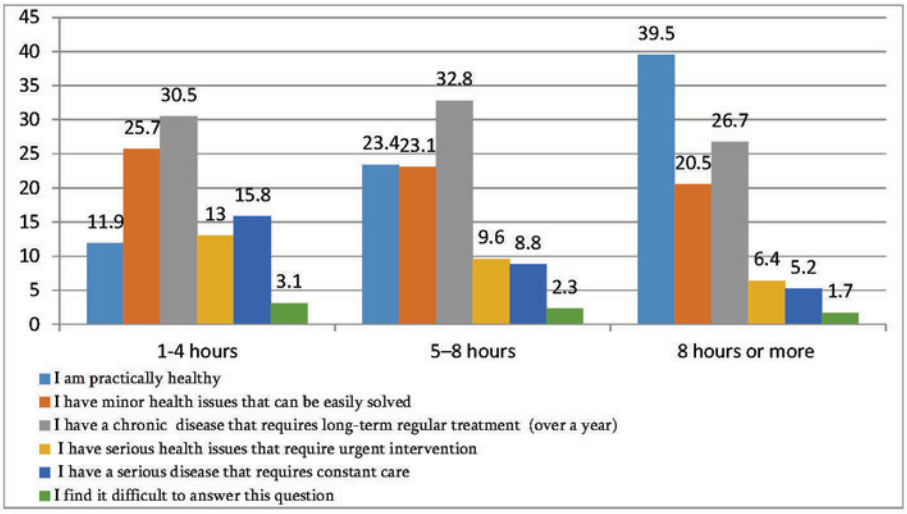

Diagram 32. Relation between presence in the open air and prisoners' health self-assessment

The majority of prisoners (60.7%) are not engaged in exercise, sport, or other similar physical activities (on their own initiative). It should be noted that the type of establishment significantly affects the length of physical activities of prisoners. 37.3% of prisoners of semi-open establishments exercise for 1-2 hours, while the respective figure in the closed establishment is only 10%.

Some of the interviewed prisoners, who noted that they do not exercise at all, named various reasons: every third person in this subgroup (35.4%) says that their health condition or age does not enable them to be engaged in physical activities; in addition, approximately the same number of prisoners (31.3%) indicates that there are no appropriate conditions for physical activities; one fifth of respondents (20.5%) say they are not motivated.

It is important to promote individual sport activities even under the limited capabilities of the facilities. For example, in case of request, prisoners should be additionally taken to the yard, where they will be able to exercise individually.

It should be noted that the walking yards of closed and high-risk establishments do not enable prisoners to be properly engaged in physical activities. The walking yards are not equipped with exercise equipment.[166] Accordingly, it is necessary to ensure appropriate conditions to enable prisoners to stay and exercise in the open air, to equip yards with exercise equipment and to increase the time daily spent by prisoners of closed and high-risk establishments in the fresh air.

[166] See Public Defender's parliamentary report 2016 http://www.ombudsman.ge/uploads/other/4/4494.pdf , pg. 101.

In order to maintain physical and mental health, prisoners should be provided with opportunities for recreational and cultural activities in all facilities.[167] It is necessary that inmates of closed and high-risk establishments be provided with opportunities to be engaged in leisure, artistic, labour, cognitive or other interesting activities at least in the cell. Every penitentiary institution should try to ensure access to educational programmes that would be as comprehensive as possible and would respond to the individual needs of prisoners in accordance with their aspirations.[168]

The individual plan[169] of serving a sentence should determine and evaluate the convicts' needs in terms of rehabilitation; an individual list of psychosocial and rehabilitation programmes should be determined for each convict, while the results of the programmes should be taken into view when assessing the risks and making a decision on prisoner's early release.[170] The study of individual plans of serving a sentence showed that they are of general nature and do not contain specific activities to be implemented during the rehabilitation of convicts. Individual plans do not provide a full picture of the measures outlined or taken by a specialist as a result of the identification of the convicts' needs and problems. Based on this, it is important to develop a well thought-out action plan for rehabilitation and to apply individual approach when choosing programmes.

The vast majority of the interviewed prisoners (80.1% -89.4%) have not participated in the rehabilitation activities. The respondents who have not participated in the rehabilitation activities name the following reasons: cannot see the necessity for it (21.9% -23.6%), do not have proper information (16% -18.7%), absence of events/programmes (9.1% -13.3%), health condition (5% -9.1%), lack of desire (1.2% -1.7%).

As for the desire to participate in the rehabilitation programmes, the percentage of prisoners having such desire varies between 37 and 41. Unfortunately, most of the respondents do not want to be involved in such events or programmes. The survey showed that the number of people willing to participate in educational/professional programmes is higher (40.4%) compared with other programmes.

It is necessary to encourage prisoners to be engaged in the rehabilitation activities, which shall be a task of the prison social department. It is important to use various forms of encouragement and to

[167] Nelson Mandela Rules, Rule 105.

[168] European Prison Rules, Rule 28.1.

[169] Convicts are involved in the rehabilitation activities according to their individual plans of serving a sentence. The mechanism for individual planning of serving a sentencce was introduced in 2015 and covered all establishments by the end of 2017.

[170] See the activity report 2016 of the Ministry of Corrections of Georgia: http://www.moc.gov.ge/images/catalog/items/zzzz.pdf [accessed on 13.04.2018]

provide adequate human resources in order to strengthen the efforts of the social department in this direction.

According to the official data of 2016, 1 325 convicts took part in vocational and educational programmes.[171] In 105 cases, prisoners were encouraged to participate in the rehabilitation activities. It turns out that only 8% out of the 1 325 prisoners were encouraged to participate in the rehabilitation activities, which is quite a low percentage.

According to the survey data, the percentages of people participating in educational programmes differ according to the types of Penitentiary Facility. In particular, higher number of respondents in the closed facility (48.7%) are willing to participate in the programmes compared with prisoners of semi-open Penitentiary Facilities (23.6%). The same difference was observed in relation to cultural activities, psychosocial rehabilitation programmes and sport activities.[172] In all the three cases, the number of prisoners willing to be engaged in the programmes is higher in closed establishments than in semi-open establishments. This can be explained by the fact that prisoners in closed establishments do not have the opportunity to be engaged in leisure, artistic, labour, cognitive and other interesting activities.[173]

It is very important to introduce diverse rehabilitation programmes tailored to the individual needs of prisoners in the closed and high-risk establishments. As the above information makes it clear, the involvement of convicts of these establishments in the rehabilitation activities is very low, which creates an unhealthy environment in the establishments and negatively affects the relationship between prisoners and prison staff, as well as order and security in the establishments. It is impossible to attain re-socialization of convicts and prevent repeated commission of crimes by them without rehabilitation programmes.

During the visits made in the course of the survey, it was found out that the number of psychologists and social workers is insufficient in the Penitentiary Facilities. According to an employee of the social department of Establishment N8, in order to ensure proper function of the social department, it is necessary to at least double the number of employees of this department[174] and even more employees are needed to ensure proper quality of the service. Since there is a lack of psychologists in the Penitentiary Facilities, as

[171] Opinions of the Ministry of Corrections of Georgia on the Public Defender's Report on the Situation of Human Rights and Freedoms in Georgia in 2015 and the recommendations included in the Parliament's Resolution.

[172] 43.8% of the respondents interviewed in closed institutions and 19.3% of semi-open establishments expressed their desire to take part in cultural activities; 42.5% of prisoners interviewed in closed establishments and 21.1% in semi-open establishments expressed their desire to take part in psychosocial rehabilitation programmes; As for sport activities, 47% of prisoners interviewed in closed establishments and 22% of prisoners interviewed in semi-open establishments expressed their desire to take part in such activities.

[173] See the Public Defender's parliamentary report 2016: http://www.ombudsman.ge/uploads/other/4/4494.pdf , pg. 116.

[174] For example, as of December 2016, 26 employees (6 psychologists, 20 social workers) worked in the social department of Establishment N8, an average of 2 370 prisoners were placed in the same facility in the same year.

well as deficiency in social relations and communication, prisoners apply to the medical personnel for emotional relaxation. The strengthening of the social department would facilitate the performance of the medical personnel.

It is noted in the Public Defender's parliamentary report 2016 that 1 218 prisoners in Penitentiary Facility N2 and 1 922 prisoners in Penitentiary Facility N17 were served by only 2 psychologists; only 1 psychologist worked with 1 152 convicts in Penitentiary Facility N14 and 1 706 convicts - in Penitentiary Facility N15. 6 psychologists worked with 2 370 prisoners in Penitentiary Facility N8, meaning that one psychologist had to work with about 400 prisoners.[175]

It should be noted that given the improper working conditions of the employees of social departments, some psychologists express regret at not having resources to conduct psychotherapy due to their busy schedule; they do not have proper material-technical resources either[176]. According to the Special Preventive Group, it is important to raise the qualifications of psychologists and social workers, as well as to provide sufficient number of psychologists and social workers and create appropriate working conditions for them.

According to the European Prison Rules, prison authorities shall strive to provide sufficient work of a useful nature.[177] As far as possible, the work provided shall be such as will maintain or increase prisoners' ability to earn a living after release.[178]

The survey conducted in the Penitentiary Facilities found that the prisoners' employment rate is very low, in particular 92.7% of respondents are unemployed.[179] Only 7.3% have the employee status. 3.7% out of them are engaged in prison labour, 1.9% - in individual activities, etc. Only 0.7% of respondents are employed in small enterprises. The employment rate of prisoners is relatively high (13.1%) in the semi-open establishments than in the closed establishments (3.8%).

The majority of the interviewed unemployed prisoners (68.4%) have no desire to be employed. They name the following reasons: the lack of necessity for the employment (18.4%), health condition (15%), absence of suitable jobs (7.1%). Some inmates think that employment of prisoners is unacceptable (5.6%). Only 24.1% of the unemployed prisoners have a desire to work.[180]

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[175] See the Public Defender's parliamentary report 2016: http://www.ombudsman.ge/uploads/other/4/4494.pdf, pg. 120.

[176] More detailed information about the working conditions of the employees of the social department is available in the Public Defender's parliamentary report 2016.

[177] Rule 26.2

[178] Ibid. 26.3

[179] 37% were unemployed before arrest.

[180] For instance, women (57.7%), prisoners aged 35 or older (40.5% in total) and convicted inmates are more willing to be employed than men (18.7%), younger prisoners aged (13.9%) and remand inmates.

On average 10 333 inmates were placed in the Penitentiary Facilities in 2015 and 9 601 - in 2016, 8.4% of these prisoners were employed in 2015 and 6.1% - in 2016. Unfortunately, the number of employed prisoners was 28.1% lower in 2016 than in 2015.[181]

Recommendations to the Minister of Corrections:

- **Solve the problem of overcrowding in Penitentiary Facilities N2 and N15 by reducing the number of prisoners there**
- **Ensure that each prisoner in the Penitentiary Facilities is provided with 4 m² of living space**
- **Abolish the so-called barrack type living spaces in Penitentiary Facilities N14 and N17**
- **Ensure that prisoners in the closed establishments are allowed to spend more than an hour in the open air**
- **Increase the number of rehabilitation activities in 2018**
- **Ensure that prisoners in the closed and high-risk establishments are allowed to spend more than an hour in the open air**
- **In order to implement necessary rehabilitation programmes, ensure needs assessment and study the best practices of various countries in 2018**
- **Talk to all convicts in order to determine the spheres of interest of rehabilitation programmes in 2018**
- **In order to motivate prisoners to participate in the rehabilitation programmes, ensure that prison director's obligation to encourage prisoners for their successful participation in the rehabilitation programme, on the basis of a petition of a person in charge of a specific rehabilitation programme, is determined at the normative level**
- **Provide uniform, basic rehabilitation programmes in similar establishments**
- **Ensure that the rehabilitation programmes implemented in the low-risk establishments in 2017 are implemented in the semi-open establishments as well; ensure that the rehabilitation programmes implemented in the semi-open establishments in 2017 are implemented in the closed establishments so that the infrastructure and safety norms are taken into view; ensure that the rehabilitation programmes implemented in the closed establishments in 2017 are implemented in the high-risk establishments so that the infrastructure and safety norms are taken into view**
- **Ensure that individual plans of serving a sentence are based on each convict's individual needs assessment and include a list of specific measures to be taken in relation to each convict, by referring timeframe**
- **Increase the number of psychologists and social workers in 2018**

[181] See the Public Defender's parliamentary report 2016, http://www.ombudsman.ge/uploads/other/4/4494.pdf [accessed on 18.04.2018]

- **Increase the material-technical resources of the social department in 2018 and provide information to the Public Defender's Office about the improvement of working conditions**
- **Set up enterprises and support individual activities in order to ensure employment of prisoners**

5.5. Violent environment as a risk factor

Violence leads to the deterioration of health, which may last a lifetime. The most common death causes, such as heart disease, stroke, tumor and HIV/AIDS are often associated with the behavior characteristic of the victims of violence, such as smoking, use of excessive alcohol and drug addiction. According to the victims, such behavior is aimed at coping with the psychological effects of violence.[182]

According to the Nelson Mandela Rules, all prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times.[183]

The sociological survey showed that prisoners experienced violence not only in the penitentiary institution, but before arrest as well. According to the survey, 11.2% of the interviewed prisoners had experienced physical violence before arrest (frequency of violence varied). As for the occurrence of physical violence in the last three years after arrest (from the moment of detention by police), it was indicated by 6% of respondents (frequency varied). 9% of the interviewed prisoners indicated psychological violence before arrest and 9.7% indicated psychological violence in the past three years after arrest.

Within the framework of the survey, respondents were asked of whether they had lost consciousness due to the head injuries for the last three years.[184] 8.8% of the interviewed prisoners said they had experienced the above-mentioned. 24.9% of the prisoners, who had lost consciousness due to the head injury, relate the injury to the physical violence committed by the officers of the Penitentiary Facility, 10% - to beating by police officers, 12% - to confrontations among prisoners (fights).

According to the Public Defender and the Special Preventive Group, the substantial risk factor of violence stems from the criminal subculture of the Penitentiary Facilities.[185] Since according to the informal prison rules, prisoners are not approved to report the cases of abuse committed by other

[182] Global Status Report on Violence Prevention, 2014, p. 8, available in English and Portuguese at: http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/ accessed on 03.01.2018.

[183] The Nelson Mandela Rules, rule 1,

[184] Respondents might receive injuries causing loss of consciousness three years ago as well.

[185] See the Public Defender's parliamentary report 2016, pg. 49-50, available in Georgian: http://www.ombudsman.ge/uploads/other/4/4494.pdf [accessed on 03.01.2018]

prisoners and it may lead to the revenge; in many cases, the victims of such violence prefer to remain silent. Consequently, the scale of physical violence among prisoners may exceed the data of both statistics and sociological surveys.

The scale of psychological violence is even more difficult to establish, as prisoners may find it difficult to understand what psychological violence is. Some prisoners may think that systematic threatening is psychological violence, while the daily interaction under strict informal prison rules and conflicts among prisoners may not be understood as psychological violence. According to the Special Preventive Group, the informal prison rules and prison environment, in any case, prevents the development of a positive psycho-emotional atmosphere and is a significant stress factor.

The Public Defender's parliamentary report 2016 includes a discussion about the establishment of violence-free environment in the Penitentiary Facilities and recommendations of the Public Defender.[186] As for the assistance to victims of violence, it is important to introduce a mechanism for the identification of victims of violence and ensure their medical and psycho-social rehabilitation. It is important to introduce a trauma-focused cognitive-behavioral therapy module in psychotherapy.

Recommendation to the Minister of Corrections:

- **Introduce a mechanism for the identification of victims of violence**
- **Develop a medical and psycho-social rehabilitation programme for victims of violence**
- **Introduce a cognitive-behavioral therapy module focused on trauma**

5.6. Length of imprisonment as a risk factor

In this subsection we will consider the length of imprisonment as a risk factor in terms of deterioration of health condition. On the one hand, long imprisonment, whether or not a prisoner is affected by the above-described risk factors (for example, violence, poor prison conditions), may still be a risk factor. Deprivation of liberty, even under human conditions, is a significant distress and therefore may be a risk to health. Long imprisonment under improper conditions increases risk factors and consequently may have negative effects on prisoners' health.

The survey conducted by the Special Preventive Group showed that most prisoners (56.2%) had been arrested once for the last 10 years, 25.9% said they had been arrested twice and 10% said they had been arrested three times. Fewer respondents indicated four or more cases of detention. The vast majority

[186] Ibid. 30-91

of female prisoners (up to 80%) were once arrested, while almost half of them indicated two or more arrests.

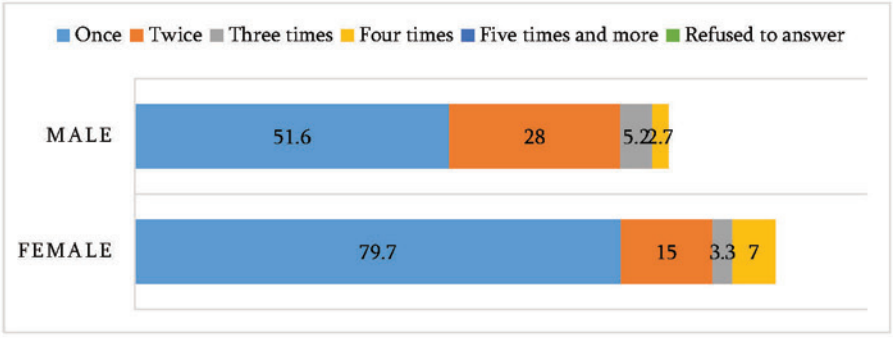

Diagram 33. The number of imprisonments for the last 10 years

The length of the period spent in the Penitentiary Facility for the last ten years ranges from 13 to 36 months for most respondents (23%).

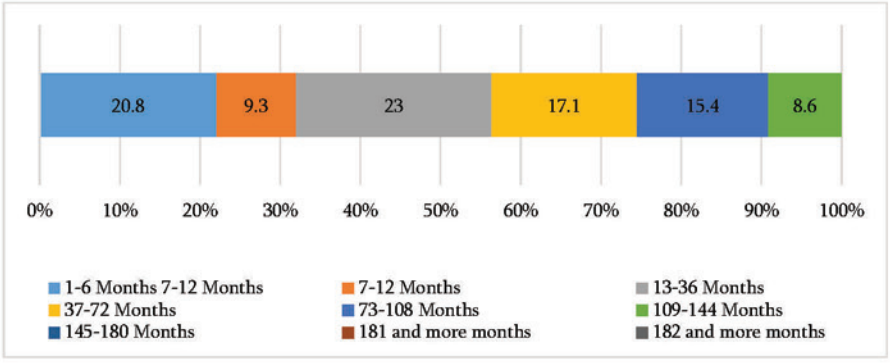

Diagram 344. The length of imprisonment for the last ten years

The socialogical survey showed a correlation between the dynamics of prisoners' health self-assessment and the length of imprisonment (see diagram N35). In case of imprisonment of up to one year, 21-23% of prisoners indicate a sharp deterioration of health. This indicator sharply increases if the length of imprisonment increases: In a group of prisoners who have been in the Penitentiary Facility for three o six years, 37% of respondents indicate the sharp deterioration of health, while in case of imprisonment for over nine years, the respective figure increases to 64%.

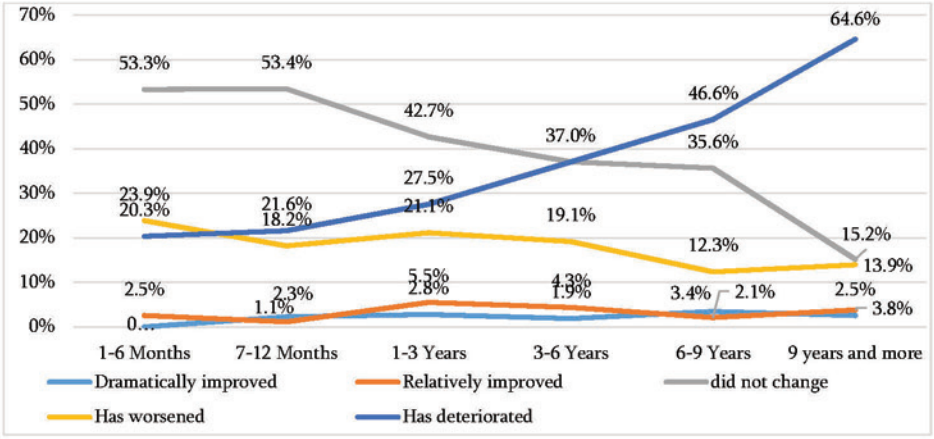

Diagram 35. The length of imprisonment and the dynamics of health condition

The length of imprisonment has significant impact on prisoners' mental health self-assessment. 15.7% of respondents indicated that they had experienced psychological/mental problems in the first six months of imprisonment. This rate reduces to 10% after the period of adaption to imprisonment (7-12 months), but then again increases twice and reaches 20%.

The survey also showed a sharp correlation between the length of imprisonment and the cases of self-injuries, suicidal thoughts and suicide attempts (see digram N36)

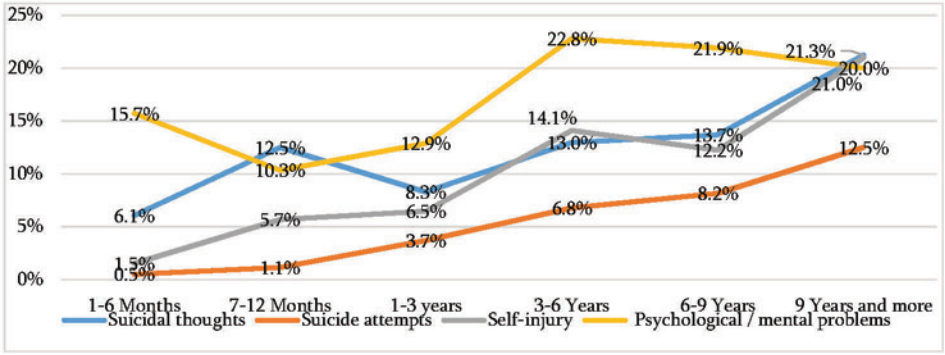

Diagram 36. The impact of the length of imprisonment on prisoners' physiological condition

All of the above makes it clear that the length of imprisonment influences prisoners' self-assessment of their mental and physical health. At the same time, it serves as a factor provoking autoaggression. Therefore, it is necessary to avoid long imprisonment as much as possible by liberalizing the criminal law and developing an effective system of early release. Particular attention should be paid to the adequate management of mental and physical health complications in case of long imprisonment.