European Monitoring Centre
for Drugs and Drug Addiction

European Questionnaire on Drug Use among People living in Prison (EQDP)

Methodological guidelines

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Introduction

Conducting a survey in a prison setting is a difficult task. The specific environment in which the survey is conducted, and the profile of the potential interviewees, poses difficulties in the development of the fieldwork and limits the methodological aspects of the study.

Some methodological aspects are described below as principles and recommendations to be followed when conducting a survey in prison. Their objective is to guarantee a high level of data quality when conducting the research and to increase the comparability of the data across countries. Another objective is to ensure that high ethical standards are maintained in the studies, taking into account the special circumstances of the target population.

A range of European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and international (the United Nations (UN) and the World Health Organization (WHO) tools have been used as methodological and theoretical references in drafting these guidelines, including the *Handbook for surveys on drug use among the general population* (EMCDDA, 2002), the *Treatment demand indicator standard protocol 3.0* (EMCDDA, 2012) and the EMCDDA drug-related infectious diseases (DRID) guidance module 'Methods of bio-behavioural surveys on HIV and viral hepatitis in people who inject drugs' (EMCDDA, 2014). UN and WHO guidelines on drugs and prison were also taken into consideration (Møller et al., 2007; UNODC, 2008; WHO, 2010; Michel et al., 2015).

The current methodological guidelines complement the European Questionnaire on Drug use among people living in Prison (EQDP). The EQDP is a model questionnaire to be used to conduct surveys on prison and drugs in the European countries. It includes 57 questions (44 questions in the short version); it focuses on the following areas: drug use and drug use patterns among people in prison outside and inside prison, health status, including infectious diseases and mental health problems, use of health services, and social reintegration.

The current guidelines provide the theoretical and methodological background for conducting prison and drugs survey. They present what should be the main principles to guide the implementation of surveys on prison and drugs conducted inside prison, what are the main methodological recommendations, including the aim of the survey, the sampling procedures, the mode of administration, the data documentation, and the operational definitions. For every question a brief description clarifies the objective of the question, the operational meaning of the wording and the methodological specifications important to consider when the questions are administered.

The guidelines also offer a series of templates that can be useful for implementing the survey. Those include: a table for collecting methodological information of the survey, an example of

informed consent to be collected before conducting the survey and a check list with the most important elements to remind and tick when conducting a prison and drugs survey.

Two lines summary of each point described in the guidelines is provided to facilitate an easy and rapid reading of the document and to facilitate the utilization of the tool.

This document represents a unique methodological tool. It is particularly relevant to ensure harmonisation of the methods used in different surveys, allowing to conduct surveys on prison and drugs that are comparable in different prisons and national contexts. The presentation of comparable results on such a relevant topic will reinforce the scientific evidence of the findings that have the ultimate goal to support and facilitate the implementation of evidence-based interventions for people with drug related problems who spend some time of their lives inside prison.

The methodological guidelines **aim to ensure the high quality** of the information collected, ensuring comparability between countries and that high ethical standards are applied. Additional national guidelines and/or more extensive instructions and rules for implementing the survey, such as fieldwork manuals, can be produced according to national or local needs and requirements.

Principles

Some general principles should be considered when establishing and implementing a survey on drugs and prison; these principles should be common at European level, as agreed in the methodological framework for monitoring drugs and prison in Europe (EMCDDA, 2013).

Aim

The aim of the survey should focus on public health and not on control.

The information on drugs and prison is to be collected from a **public health perspective** and should **NOT** focus on the principle of control. The public health perspective should be the driving force for gathering any type of information in the context of the survey on drugs and prison. The aim is to collect information that can be used to improve health, social services and facilities for people living in prison and ultimately to improve the physical, psychological and social conditions of people living in prison; this should improve the health of the whole community. Conducting survey on prison and drugs will also provide important information on the people with drug related problems in general regardless of the setting.

Survey management

The survey should be managed by institutions/persons independent from prison system.

The national institutions and state administrations responsible for health at the national level (the ministry of health or the public health institute), for prison issues (the prison service or the ministry of justice) and for drug policy and drug monitoring (the office for drugs, drug commissioner, national drug coordinator or national drug observatory) should be informed about upcoming research projects by institutions planning to carry out research in prison settings. If possible, they should be involved in the planning and management of the research project and the organisation and assignment of tasks. If such a body contracts the research, it should also be in charge of the survey's funding and coordinate the analysis and use of the results. The judicial and penitentiary administration systems should support the implementation of the survey and the fieldwork. Incentives for participating in the study may be used in the same way as when conducting surveys in the general population. The survey should be carried out **by institutions that are independent of the prison setting** and are known for their high scientific and professional standards (Aebi et al., 2014).

The **checklist in the Annex 4 of this document** summarises the important steps in conducting a survey in prison settings.

Existing tools

Adapt national tools to the existing questionnaire rather than developing new ones.

When designing a survey that will be implemented in prison settings in a European country, it is advisable to consider **existing tools at national level rather than developing new tools**, if possible, to harmonise the survey with European guidelines and thereby obtain added value at both national and European levels. It is advisable to adapt existing national tools and harmonise them with European guidelines to increase their added value. If tools for data collection do not exist at national or local level, they should be developed in line with European guidelines.

Questionnaire/data collection form

EQDP is a model questionnaire to be used to allow data comparability and facilitate the implementation of surveys on prison and drugs.

The tool published with these methodological guidelines is the **European Questionnaire on Drug Use among people living in prison (EQDP)**. European countries are invited to use the **model questionnaire** in prisons to collect information on drug use among people living in prison. The objective of having a common questionnaire is to obtain the same information in every country at European level; the information collected will be based on harmonised definitions and guidelines. Nevertheless, each country can adapt the questionnaire to its national language and to its specific needs and national or local context. Additional items can be included for national or local purposes. Some questions might not be relevant for the country's context; others might be regarded as too sensitive, especially those referring to current imprisonment, which are marked with an exclamation mark: (!). One or more of these questions may be omitted, according to specific needs.

Minimum core dataset

EQDP propose a minimum core data set for all European countries. Every survey can add more information according to specific needs.

The proposed questionnaire is designed to provide a European **minimum core dataset common to all European countries**, ensuring the consistency and comparability of the data collected in different countries. As collecting data in prisons is a complex task, a long and short version of the EQDP have been created to allow the prioritisation of some information areas whilst keeping a high degree of harmonisation across countries.

Short and long version of the EQDP

Two version of the EQDP are available: a long version with 57 questions and a short version with 44 questions.

Since data collection in prisons is very complex and countries may not be able to invest significant resources in carrying out a survey, **two versions of the EQDP** have been written: **a short version, which includes 44 questions and a long version which includes 57 questions**. The long version includes the same questions as the short version while it assesses some additional items relevant for specific national contexts.

The objective is to allow a minimum set of common questions and also to make possible for all countries to achieve their information needs. In this regard, when using the short EQDP version it is highly recommended to use it without amendments of any kind.

Next to the number of each question of the long version listed in the methodological specifications below (starting at page 22), the number of the question of the short version of the questionnaire is put between brackets (there are files available for both questionnaires).

The long and short version of the questionnaire have the same sociodemographic items in section 1: Q1.1 to Q1.14.

In section 2 the short version of the questionnaire has kept only two questions regarding substance use outside prison Q2.0 (Q2.1 in the short version) and Q2.2 (Q2.2 in the short version; current frequency of use) and only one related to substance use inside prison Q2.6 (current frequency of use Q2.3 in the short version). The short version of the questionnaire focusses on the current use of illicit substances of main interest in drug research. The following substances are not taken into account in the short version: tobacco (cigarettes) and alcohol (beer, wine, and spirits) pharmaceuticals without a doctor's prescription: Methadone, Buprenorphine, Fentanyl, Barbiturates, Benzodiazepines and volatile inhalants/solvents (that may be recorded in the option "Other substances").

In section 3, the short version of the questionnaire has kept only two questions regarding injecting substances and share of injection equipment, options asking about injecting and sharing IN ANY PRISON were dropped, as well as the item regarding tattoos.

In sections 4 and 5, the short version of the questionnaire has the same number of questions than in the long version Q4.1 to 4.21 and Q5.1. to 5.2., respectively.

Last but not least important, section 6 is not included in the short version.

Triangulation of sources

Data collected through the EQDP should be triangulated with other information sources.

Data collected through surveys in prisons have several limitations relating to the specificity of the setting and the sensitive nature of the subject being studied (drugs). It is therefore important to **triangulate the survey's results with other information sources**, which may come from other studies, routine data collection or other, unofficial, information sources (Carpentier et al., 2012).

Terminology

The terms used in the questionnaire should be adapted to the original language and literacy level of the respondents. The words used should be respectful and appropriate in line with international ethical standards.

Particular attention should be paid to terminology, both in the questionnaire and in the methodological guidelines adapted to the national context. **The language and health literacy level** used in the questionnaire should take into account the **specificity of the prison environment**. The language should be understandable, adapted to the cultural and educational level of the people living in prison taking into account weak health literacy competencies, and written in the language that they speak (which may differ from the official language of the country where the prisons are located). In some countries, the majority of people living in prison are foreigners, and the questionnaire may need to be translated and/or interpreted. Particular attention should also be paid to translations from English into national languages, to retain the exact meaning of the wording used in the European questionnaire and thus ensure the harmonisation of the data. In some instances, the use of supporting material (images of the drugs referred to in the questions) should be considered to facilitate comprehension of some of the questions, particularly those relating to the consumption of new psychoactive substances (NPS). The use of the terms should follow high quality standards and be in line with the principles of respect of human rights. The use of respectful and appropriate language is a cornerstone of reducing harm and suffering when working with people involved in the criminal justice system; the use of stigmatizing and dehumanizing language must therefore come to an end. For that reason, the questionnaire has replaced the word "prisoner" but people living in prison (Wolff, 2018).

Ethical standards

In conducting the survey high ethical standards should be followed and permission from the ethical board or the institution in charge of ensuring the respect of ethical standards should be obtained.

Collecting data in prison settings is a sensitive issue, and **ethical principles should be carefully considered** at every phase of the survey. High ethical standards should be set before the survey starts and maintained during its implementation. If one is not already in place, an **ethical board should be set up** to assess the implementation of ethical principles in the survey. The study should be evaluated and approved by the ethical board in accordance with national standards. In addition, rules defined by European rules for data protection should be followed as well as those defined at national level by the data protection officer.

For those reasons a disclaimer on data protection is provided at the beginning of the questionnaire, referring to the European rules (see following paragraph).

The survey should be carried out in a way that promotes its potential benefits for the people living in prison. The people living in prison should be informed about the aim of the survey, they should provide written consent for their participation, and they should be informed about how it will be managed and how its results will be used.

The survey should be fully anonymous; if anonymity cannot be guaranteed or any identification of people living in prison is part of the study design, a written informed consent is vital. Full anonymous data collection may reduce response bias, as also avoiding any type of sensitive question and adapted health literacy used in questionnaire. With regard to the specifics of the prison population, evaluation by the ethical board is recommended. The survey should not be used to attempt to change people living in prison' drug use patterns or to influence them in any way; the only goal of the survey must be to collect the absolutely necessary (i.e. minimum) information for monitoring, statistical and research purposes. This should be made clear to people living in prison and to the prison administration before the study starts.

If juveniles are participating in the survey (even if they are in custody), special permits should be obtained from parents or legal guardians. This condition will also apply to anyone under legal guardianship, which might be a relatively high proportion of people with a long history of drug use.

Data protection

Rules for data protection established at European level and at national level should be followed.

International rules on confidentiality and data protection and guidelines for respecting people living in prison' rights, including human rights, must be followed. In particular, the following two international guidelines should be considered to be reference points when implementing the survey: *Human rights and prisons: a pocketbook of international human rights standards for prison officials* (UN, 2005) and the WHO guide *Prisons and health* (Enggist et al., 2014). These guidelines should be read and taken into consideration when implementing research and surveys in prison settings. Furthermore, principles for conducting medical research in a way that respects the health of the survey participants should also be followed (Council of Europe, 2005). All the people and institutions involved should be informed about and aware of these principles and rules, including the interviewers, prison staff, people living in prison and all subjects involved in the survey (UN, 1990, 2005; Enggist et al., 2014). A model of form for obtaining the informed consent of the study participants is provided in the Annex
According to the Regulation[1] (EU) 2018/1725, 'personal data' means any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person. The EQDP questionnaire is a health survey aiming to gather information which will then be used to improve health, social services and facilities for people in prison and ultimately to improve their physical, psychological and social conditions; all in all, will have a positive impact in the health of the community in general. Health data, collected using the EQDP, belongs to special (sensitive) categories of data, the processing of this data is necessary for reasons of public interest in the area of public health; scientific research and statistical purposes, based on EU laws, respecting the right to data protection and provide suitable and specific measures to safeguard the fundamental rights and the interests of people in prison (data subjects). Measures for anonymisation, understood as rendering impossible the identification of an individual, may be implemented when authorising access to data to a third party. See recommendations on anonymity and confidentiality in the guidelines.

[1] Regulation (EU) 2018/1725 of the European Parliament and of the Council of 23 October 2018 on the protection of natural persons with regard to the processing of personal data by the Union institutions, bodies, offices and agencies and on the free movement of such data, and repealing Regulation (EC) No 45/2001 and Decision No 1247/2002/EC (Text with EEA relevance.) PE/31/2018/REV/1
OJ L 295, 21.11.2018, p. 39–98 In force ELI: http://data.europa.eu/eli/reg/2018/1725/oj

Guidelines

Survey aims

The aim of the survey is to increase knowledge on the drug related needs of people in prison with the ultimate goal to improve drug related services.

The aim of this survey is **to increase knowledge** on drug use among people living in prison, their health status and related consequences, and to **better understand the health, psychological and social needs of people living in prison relating to the drug problem**. This information can facilitate the development of appropriate public health and social services (treatment, prevention, harm reduction, etc.). The survey should also ultimately make those services more accessible for people living in prison or people who had lived in prison, both inside prison and at an early stage after release.

Transparency

The objective of the survey should be explained to the respondents and every doubt clarified.

It is important **to explain the objective of the survey to respondents** to ensure that the data to be collected can be used to meet the general aims of the study and of the established methods and tools for (repeated/regular) data collection.

Method of the survey

The method chosen is a cross sectional survey.

The method used to administer the EQDP should be based on a **cross-sectional survey** among people living in prison on their drug use, patterns of drug use inside and outside prison, health problems that may be related to drug use, and their use of drug and health services.

The decision to define a common questionnaire emerged after a process of analysis and revision of available prison and drugs data and of assessment of existing data collection tools. The outcome of those analysis showed the need for harmonisation of data collection tools and in particular it was identified the need to arrive to a common European questionnaire as valuable tool for data collection. In 2014, a specific assessment of information and methodologies was conducted, collecting and assessing the structure of, and information from, over 40 questionnaires and data collection forms on drug use among people living in prison that had been used to conduct surveys in prisons in 23 European countries (Carpentier et al., 2012; Royuela et al., 2014). The EQDP was then revised in 2016, based on the results of the project “Support the EMCDDA in piloting the EQDP”; the revision took into account the

experiences and recommendations of five participating countries (the Czech Republic, Italy, Poland, Portugal, Slovenia). In addition, experts from Belgium, Spain and France contributed to the exercise on the basis of their experiences of the on-going implementation of national prison surveys.

Periodicity of the survey

The survey should be conducted every two years; is this is not possible it is recommended to conduct the survey with a maximum interval of four years.

It is recommended that the proposed questionnaire is administered **every two years**, as in the case of the general population surveys. AS this time period may be challenges for some countries and following the recommendations made in the assessment of the implementation of the key indicator 'General population surveys', it is recommended that the **maximum time interval** between two surveys should be **four years** (EMCDDA, 2002).

Target population

Respondents to the survey are all people living in prison in the given period chosen for conducting the survey.

The target population of the survey should include **all people living in prison on a given day or during a given week in all custodial institutions**. The categories of people living in prison included are those specified by Aebi et al. (2014).

The people living in prison are divided into the following categories according to their legal status and their place of imprisonment.

A. people living in prison by legal status:
   a. untried detainees (no court decision yet reached);
   b. sentenced people living in prison who have appealed or who are within the statutory limits for doing so;
   c. detainees who have been found guilty but have not yet received a sentence;
   d. detainees who have not yet received a final sentence but have started serving their custodial sentence in advance;
   e. sentenced people living in prison (serving their final sentence);
   f. people living in prison under administrative arrest, which refers to a sanction of temporary detention under administrative law (i.e. not included in criminal records).

B. People living in prison by place of imprisonment:

a. persons held in penal institutions designed for custodial sentences;
b. persons held in remand institutions (generally designed for pre-trial detainees and for those serving short-term custodial sentences);
c. persons held in custodial and/or educational institutions/units for juvenile offenders;
d. persons held in police stations (if these stations are under the authority of the prison administration and if the persons held have the status of inmates);
e. persons held in institutions for drug-addicted offenders outside penal institutions (if the persons have the status of regular inmates);
f. persons with psychiatric disorders who are held in psychiatric institutions or hospitals outside penal institutions (if the persons have the status of regular inmates).

These groups may vary by country, as not all categories apply to every country. For that reason, the categories of legal status have been simplified as follow in agreement with the country experts: on remand/Pre-trial/not yet sentenced; convicted serving sentence; held under administrative detention; not stated/refused.

Countries should specify what the situation is regarding groups of people living in prison at the national level. It will be necessary to specify which groups have been included in and which excluded from the survey, as it is possible that, for practical reasons, some groups will not be included (e.g. people in psychiatric institutions).

Access to prisons

Obtain specific agreements with prison authorities and establish and reinforce connections with both ministries in charge of the prison organisation and the health management inside prison.

It is important to **establish or reinforce connections** with prison institutions and in particular **with the ministry of justice or ministry of the interior** (according to country), which are responsible for prison management and for the access to prisons' databases of inmates. This will be useful for defining a sample of people living in prison for the survey. **Specific agreements** should be established with the relevant authorities. The conditions for accessing prisons should be established in a specific agreement between the institution responsible for the survey and the local authorities (e.g. prison directors).

Sampling

The preferred sampling method is a random multistage sampling. Population underrepresented in prison should be overrepresented in the sample. The final choice however depends on the study's main objectives.

The sampling method will depend on the objectives of the study. The sample should be **representative of the entire prison population** (EMCDDA, 2002) and, ideally, should be chosen **randomly** using the population registered as being in prison on a given day or during a given week. If possible, a **multi-stage sampling method** (i.e. a type of cluster sampling) should be used; this type of sampling method anticipates several levels of cluster selection that may be applied before the final sample elements are reached. The survey will then focus on specific chosen clusters. To ensure sufficient information on groups of people living in prison with particular health and social needs, **these groups should be over-represented in the sample**. They may include women people living in prison, juvenile detainees, young adult offenders, foreigners or others, and these groups may vary between countries. It is advisable that the sampling is defined (or supervised) by the research institution conducting the survey, rather than by the prison service administration, to avoid bias.

Sampling methods are grouped into two main categories: **random (probability) sampling and non-probability sampling.**

A. <u>Random (probability) sampling:</u>
   a. Simple random sampling: all inmates have the same probability of been selected to participate in the study/survey, for example selecting the inmates using a table of random numbers.
   b. Systematic sampling: selecting inmates from the prison/s census. Systematic sampling involves a random start and continues with a selection of every k^{th} inmates; where k is the equal to the prison population size divide by the sample size. For example, it would be selected every 5^{th} element from the prison census.
   c. Stratified sampling: When the prison population holds distinct categories (e.g. Judicial status: on remand and sentenced) the selection can be organised into these two different independent groups, where the inmates will be randomly selected in each stratum. Every inmate in the group will have the same probability of selection. In case of minority group, for example women or foreign nationals, in the same prison, the representation of one group could be ensured by varying the sampling fraction. The overrepresentation of the number of inmates in one of the groups would require weighting, to improve the precision of a sample's estimates.
   d. Multi-stage sampling: this method consists in taking a random sample of previous random samples when two or more levels of units (judicial status, gender) are embedded

one in the other. For example, random selection of on “remand prison settings” followed by a random selection of inmates in each setting.

e. Cluster sampling: this method starts by identifying the clusters in the first stage (e.g. list of regions, cities, geographical areas with detention institutions) and in the second stage, all inmates of the clusters selected should be included in the study. In this method the sampling unit are groups rather than individual inmates.

B. Non-probability sampling:

a. Convenience sampling: the method is based on opportunity; the sample is drawn from people in prison available or convenient for the study.
b. Purposive sampling: the sample in this method is selected based on the characteristics of the prison population, is a selective sampling for example, all inmates entering prison, inmates tested on suspicion of drug use, inmates injecting drugs sharing injecting paraphernalia.
c. Quota sampling: inmates would be part of the study sample according to some characteristic (e.g. gender, judicial status, nationality, time in prison, drug behaviours). People in prison seen with the same characteristic should be asked to participate in the research. For example, the nationalities of inmates assign a quota of 30% foreigners and 70% nationals. The selection of inmates will not stop until is reached the quota, once reached one of the quota (e.g. national inmates), the selection should continue until the other quota, foreign inmates, is reached, therefore rejecting inmates for the group of national inmates.
d. Snowball sampling: this method is based on building the sample using networks. It is a chain-referral method used to study small subgroups of the population (e.g. problem NPS users in prison). The initial inmates selected should identify/nominate other inmates to be asked to participate in the study, continuing in the same way until it is reached the sufficient number of inmates for the study.

Specific exclusion criteria may be applied when implementing the survey according to the aim of the survey, the specific context in which the survey is conducted and the characteristics of the respondents.

Introduction to the interview

The survey’s aim and modalities should be explained to the respondents and involved prison staff involved before implementing the survey. Guarantee should be regarding anonymity, confidentiality and use of the results.

Before the data collection begins, the people living in prison must be briefed about the general and specific objectives of the survey, including how it will be organised and how the

final results will be used. It is very important to **inform each participant about the benefits of the survey**, the rights of participants, and how **anonymity and confidentiality** will be handled. It is also necessary to explain how the results of the study will be used, particularly regarding public health benefits. This is particularly important because the information obtained from the survey will be used to assist stakeholders in developing public health programmes that aim to minimise the risk factors that relate to and lead to drug use and related problems (e.g. infectious diseases, overdoses). The questionnaire can be introduced by talking to people living in prison or by using letters or leaflets. It is important to ensure that people living in prison are informed about and aware of the survey and their participation in the study. An introduction to the survey should also be provided to prison staff and management, including the prison administration (directors, etc.); this can also be done in meetings and/or using written information.

Individual rights of the participants in the study

People can decline at any time their participation in the survey. It should be ensured that both participation or non-participation will not lead to any sanction.

People living in prison selected to participate in the study **may decline to take part**, withdraw their consent at any time or choose not to answer any question in the survey. **These decisions must not entail any sanctions for the people living in prison.**

Anonymity and confidentiality

Anonymity and confidentiality of the answers should be ensured.

Participation in the survey and the data it provides must be strictly confidential. The respondent must be assured that his or her responses will remain confidential. It is not enough to simply state this; it should also be obvious from the setting of the interview and the traceable procedures for handling the completed questionnaires. It should be made clear to the participants that, while the data from the study may be sent elsewhere for analysis, no personally identifiable information will be provided for this analysis. The length of storage of the data (time until it will be deleted digitally and/or paper-based) and who to contact in case of any additional questions / issues about data protection should also be included in the informed consent. Only results without personal identification will be published. People living in prison' names and numbers will not appear in any output document from the study. The **confidentiality of all participants is guaranteed**, and inmates' names or identification numbers should not be written on the questionnaire. Each participant must provide **both verbal and written consent** before taking part in the survey. If the questionnaire is self-administered, participation in the survey is in itself evidence of consent. In case anonymity

cannot be guaranteed, written consent is necessary. Every country and institution responsible for the survey is free to make its own decision on the best way to guarantee interviewees' anonymity. Completed questionnaires can be placed in empty and unmarked envelopes and then placed in a box (in a similar way to school surveys such as ESPAD (the European School Survey Project on Alcohol and Other Drugs). A template form for requesting the informed consent is provided in the Annex 2.

Non-response

Some basic information on non-response should be recorded to model non response.

If a selected inmate declines to take part in the study, his or her refusal should be accepted. **Some information on non-response could be recorded to model non-response** and allow the findings to be analysed in the data management phase. However, attention should be paid to maintaining anonymity and confidentiality in the management of non-responses.

Data collection methods

Data can be collected through Self-Administered questionnaires filled in with pen and paper or Computer Assisted Personal Interviewing (CAPI) or Face-to-Face interviews. Each of them has advantages and disadvantages that should be considered according to context and survey's objectives.

The choice of a method of data collection is a crucial decision when designing a survey. This is also true for surveys in prison settings. Each approach has advantages and disadvantages and may have drawbacks and generate bias that could affect response rates and the reliability of the answers that are obtained. The type of method chosen therefore has implications for the quality and quantity of the survey results. Some data collection methods may result in insurmountable problems, whereas others may be ideal for developing and easy and powerful solutions to problems.

The EQDP has been designed for **self-administration by the people in prison**, either by using computer-assisted personal interviewing (CAPI) or as a pen-and-paper questionnaire**. Face-to-face interviews** might be considered, although, taking into account the specificity of the prison setting, this might not be feasible in some countries and may involve investment and logistic limitations.

Sometimes, a mix of methods to conduct the survey may be appropriate, as in the case of sensitive questions that might be better answered without the intervention of an external interviewer. Decisions on this should be taken by those responsible for the survey. A mixed approach may involve limitations in data comparability, but it may also increase the validity of

some answers. It is, however, extremely important to describe in detail the method used for the whole questionnaire or the various parts of it.

Although there is no obligation to choose one specific data collection method, and it is up to the country and the research institution to decide on the most suitable method for use in their survey, limitations in future data comparability should be considered when deciding on a method that is not included among those listed below.
A short description of each method is provided below, in order of preference; the method used will depend partly on practical constraints (budget, premises, logistics, etc.).

1) Self-administered questionnaire

Self-administered questionnaires ensure confidentiality but has risk of multiple missing answers.

This method can be applied using standard pen-and-paper questionnaires. The questionnaire is distributed to the inmates by the people who are considered the **'contact persons'** in the prisons. The contact persons should have the ability to guarantee anonymity and confidentiality; staff who are already working in institutions (health services, universities, research institutes, etc.) and are independent of the prison services would be the preferred choice. A sufficient number of contact persons should be involved. After the questionnaires have been completed, forms should be placed in unmarked envelopes to be collected by the contact persons from each prison. The responses are subsequently compiled by scanning the survey forms or by manually entering the results into a database before analysis.

Advantages

This method requires only a simple and low-cost infrastructure. The people living in prison' confidentiality is guaranteed.

Disadvantages

A disadvantage may relate to the accuracy of the answers and the likelihood that there will be a high rate of incomplete forms. In addition, the researchers cannot control for double counting, although it seems rather unlikely that a single people in prison would complete the questionnaire repeatedly. The data management phase would also be relatively complex and time consuming.

2) Computer-assisted personal interviewing

CAPI ensure internal consistency, but it is costly, difficult to implement in prison and involving fear of confidentiality break.

CAPI ensures confidentiality, autonomy and a safe setting in which to respond to the questions. The interviewee is given a computer or tablet and asked to complete the

questionnaire, although he or she can ask the interviewer questions if clarification is needed (Lavrakas, 2008).

CAPI is user-friendly and provides an efficient way to manage data. However, some preconditions must be established with the prisons before it is used; it should be ascertained that the prisons will allow the use of electronic devices, such as laptops, tablets, smartphones, etc., that are password protected and contain encrypted surveys. The development of user-friendly interfaces has proceeded rapidly, with functions such as touch screens, colour graphics and images (which are particularly important for questions regarding the use of NPS), sound, the ability to record respondents and means of answering open-ended questions now available. The technology is increasingly user-friendly, so respondents do not need to be experienced computer users. Training should be provided to those in charge of implementing the survey.

Advantages

This method has the advantage of enabling the incorporation of automatic consistency checks. Interviewers can be alerted to any inconsistencies in the data and resolve them with the interviewee during the process. The data are controlled for double counting and correctly coded, and missing values are assigned for all items. The interview can be administered in a short period of time. The role of the interviewer is strictly controlled, yielding higher quality data. Data are recorded, exported and integrated into a database, and they can be managed rapidly and economically.

Disadvantages

Despite these advantages, debate continues about what effects this method might have on survey outcomes compared with methods such as face-to-face interviews. Questions can be misinterpreted or misunderstood, for instance, as is the case with self-administered questionnaires, and concerns about confidentiality and fears relating to external and remote controls on the survey information have also been raised in this specific environment. In addition, the method might be too expensive, its development might be complex and/or time consuming and might not be well suited to the actual conditions in the prison setting.

3) Face-to-face interview

Face to face interviews ensure accuracy but is costly and time consuming.

The face-to-face interview is carried out on prison premises by trained interviewers. The interviewers should be instructed on several topics relating to the survey methods; the use of supporting materials, such as images of the drugs referred to in the questions, to facilitate answers; and the prison environment. These topics might include interview skills; methods of conducting an interview; how best to approach prison organisations; making appointments to brief people living in prison and carry out interviews; keeping track of interviews and non-

responses; informing people living in prison and obtaining consent; and giving feedback to people living in prison.

The face-to-face interview is a personal encounter between interviewer and respondent. The interviews are structured by means of a standardised questionnaire. The interviewer asks the questions and fills in the pre-coded answers. When sensitive issues are involved, the interviewee may complete parts of the questionnaire without the interviewer's participation and hand it back to the interviewer in a closed envelope or post it back later.

Advantages

This method has the advantage of ensuring the accuracy of the answers and the quality of the information given to the respondents on the survey's aim and the exact meaning of the questions. Questions that might be difficult to understand for some people living in prison can be easily explained in a face-to-face interview.

Disadvantages

This method has the disadvantage of being more expensive (time and human resources) than the other methods. Being carried out in a sensitive setting, such as a prison, this method might be seen as less likely to ensure anonymity and confidentiality. Therefore, the use of this method may result in a higher rate of false responses or non-responses to sensitive questions. It is more time consuming than the other methods.

Data management

Data management should be planned in advance defining the format of the data and the software to be used. The following issues should be considered: data protection, missing values, data documentation, data quality.

Data management is an important phase of the survey and **should be planned in advance**, in detail and for every phase. It is necessary to decide what **format the data** should have after the data collection, **who should enter the data** and how, **which software** should be used for collecting and analysing the data, etc. Some of these decisions will depend on the method chosen for the survey; for instance, the data may be scanned or entered manually in the case of face-to-face interviews but automatically entered into a database if CAPI is used. Manuals and scientific guidelines for conducting social research may be consulted for more detailed information on how to handle data management in a survey (Neuman, 2011).

Missing values

Missing values will always be included. Strategies to reduce missing values should be identified as well as ways to deal with missing values. Threshold for accepting missing values should be established.

Respondents do not always answer questions in the way that the survey designer expects. This may be because the respondent does not want to answer a particular question, does not understand a question, skips a question accidentally or assumes incorrectly that the question does not apply to her/him. As a result, survey data will include missing values and inconsistent values. The **number of missing values** and inconsistencies **can be reduced** by choosing an appropriate method and questionnaire design, but they cannot always be avoided. For example, it is preferable to administer questions in small than large tables including too much information. This is particularly true for self-administered questionnaires (standard pen-and-paper questionnaires), where an interviewer cannot intervene. A computer program can help to prevent respondents skipping questions by guiding them through the survey and can draw attention to inconsistencies with previous answers.

There is no standard solution for handling these problems. **The threshold for missing data should be flexible depending on the characteristics of the structure of the dataset**. Questionnaires in which **more than three-quarters** of the questions have not been answered should be considered a potential source of bias. By excluding these questionnaires, the percentage of missing data for specific items will decrease. In addition, items for which values are missing in more than a quarter of the sample could bias the analysis. There are several ways of dealing with these items; some researchers will carry out an analysis to investigate the missing data imbalance in all relevant items and determine whether or not respondents with and without missing values have different characteristics. Applying methods for imputing missing data is another possible solution; alternatively, the items could be excluded from the analysis, although this is not recommended, as this would reduce the response rate because the number of “partial Interviews” is one of the main factors used to calculate the response rates, together with number of “complete Interviews”, the number of “refusals”, the number of “non contacts” and other factors (e.g. number of respondents not available on the day of the interview for health or other reasons) that can influence the response rate. Whichever approach is chosen for handling missing values, the method should be documented, both when corrections are made to the original data and when cases are excluded from the original data file.

Data documentation requirements

Process of data collection, recording and analysis should be documented. Problems encountered and solutions described in a technical report.

The overall procedures used in the implementation of the survey and subsequent data management need to be **clearly documented** by the institutions leading and conducting the survey in prisons. Ideally, this should be part of a full technical report that describes the problems encountered during the implementation of the survey and the way in which these problems were solved, as well as providing a full account of the responses.

Data quality

Measures to ensure data quality should be applied in every phase of the survey.

Data quality is an important issue in relation to data on drugs in prisons. Attention to data quality is even more important when the data form part of a European dataset, where information should be comparable across countries and consistent over time**. Measures to ensure data quality should be applied in every phase of the survey**, from data collection to data analysis. Basic validation procedures should be implemented on data completeness, consistency and timeliness, and outliers should be identified from the general prison picture, past surveys and surveys in prisons other than the prison currently involved in the survey. The identification of outliers among countries is particularly relevant for the European dataset, as these might indicate real differences between the countries or a lack of comparability at the methodological level. Methodological information should be reported and described accurately and in detail during the phases of data collection, entering, reporting and analysis.

Methodological specifications by section and question:

Record methodological information on the process of data collection, analysis and reporting and problems encountered and solutions adopted.

For every survey detailed methodological information should be included. It is recommended to record the information method (design), year of data collection, number of prisons included and prisons in the country, inclusion and exclusion criteria, sampling method, number of respondents, data collection mode, languages used in the questionnaire, method of survey administration, setting of survey delivery, time of administration of each questionnaire, total cost, n. of staff involved in the survey, research staff, health staff, prison staff, other. An example of a table that can be used to collect methodological information is provided in the Annex 1.

Personal Identifier (PID)

It is advisable to include a personal identifier (PID), although it is not included in the European version.

A “personal identifier” in not included this model questionnaire. Each country should outline its own priorities and actions regarding including and management of a PID.
A PID is a combination of characters (letters or numbers) that can be used to link the questionnaire with the person that provided the answers to the questions. The PID can be built using concatenation of alphanumeric variables or using a sequential number.

The following questions are all included in the questionnaire. First, bear in mind that the questions bellow, depending upon the method administered, may or may not require to be complemented by the necessary instructions, either for the interview or/and interviewer, to guarantee that the questions are correctly understood and appropriately answered.

Section 1. General information

Objective of this section is to gather information on the socio-demographic and legal status of the person as well as on her/his prison history.

EQDP-1.1 (EQDP-1.1 in short version) Date of interview.

This data will allow to have information on the context survey

This variable indicates the date (YYYYMMDD) in which was completed the survey. In countries where the collection of the day (or month) of the interview might jeopardizes the anonymity of the interviewees because the prison can be identified, either variables should not be collected.

The anonymisation rules applied to this variable are:

1 Create two variables: first “year” (EQDP-1.1.1) extracting the value of the year (YYYY) from the variable “Date” and second variable “month” (EQDP-1.1.2) extracting the value of the month (MM) from the variable “Date” and recoding into the value “06” in all the records. After creating the two variables, clear the variable “Date” from the dataset.

EQDP-1.2 (EQDP-1.2 in short version) Sex.

This is a basic information and focuses on biological sex at birth.

The variable “sex” refers to the inmates’ biological characteristic (reproductive functions), it has two possible categories: “1” Male and “2” Female. However, a third category was added to the variable the value “9” Not stated/refused. The variable refers to biological sex. It does not include any gender dimension. No anonymisation rules apply to this variable will remain unaltered.

EQDP-1.3 (EQDP-1.3 in short version) Age.

This is basic information and is recorded at the date of the interview

Age at the time of the survey, the value might range between 18-90 years old. However, the range of values will depend on the type of prisons included in the study (e.g. juvenile detention centres for under 18 years old). The “date of birth” can be suggested as an alternative to the age of the inmate but further data recording is required to calculate the age (date of the interview minus the date of birth) as well as some anonymisation rules (recoding the month to the value “06” and the day to the value “15”). No anonymisation rules apply to the age at the time of the survey. If the date of birth ca not be recorded as it may represent a risk of breaking anonymity, the year of birth should be recorded.

EQDP-1.4 (EQDP-1.4 in short version) Nationality.

This is basic socio-demographic information to know the nationality of the respondent

This variable is included in the questionnaire as an open alphanumeric question. It should be fill in as the “Nationality” identified by the respondent. This open question should be adjusted

according to national standards. Also, it could be codified following international standards UN[2] ISO numeric-3-code. When the survey is carried out in an EU member State, an alternative variable to the open question, to ensure anonymity, might be a variable with four mutual exclusive categories:

1 “National” 2 “National of other EU Member State” 3 “National of other European country” 4 “National of non-European countries”.

(EUROSTAT includes a variable of three categories in the European Health Interview Survey (EHIS[3]):

Question HH04 What is your citizenship?

1 “Nationals”; 2 “Nationals of other EU Member State” and 3 “Nationals of non-EU countries”.

EQDP-1.5 (EQDP-1.5 in short version) Country of birth.

This is basic information to allow to assess the country of origin of the person

This is as open alphanumeric question for providing the name of country where the inmate was born. This open question should be adjusted according to national standards. Also, it could be codified following international standards UN[3] ISO numeric-3-code. When the survey is carried out in an EU member State, an alternative variable to this open question, to guaranty anonymity, might be a variable with four mutual exclusive categories:

1 “National” 2 “National of other EU Member State” 3 “National of other European country” 4 “National of non-European countries”.

EUROSTAT includes a variable of three categories in the European Health Interview Survey (EHIS[4]):

Question HH03 What is your country of birth?

1 “Nationals”; 2 “Nationals of other EU Member State” and 3 “Nationals of non-EU countries”.

Prison administration and policymakers use statistics regarding nationality and country of birth to set specific immigration policies inside prison. Understanding different immigrant groups’ needs will help setting policy regulations against discrimination based on national origin. Statistics will be use to plan and implement socio-health services to accommodate cultural differences. However, in countries where collecting these items is against national data protection laws, they may drop these two questions in their questionnaires.

EQDP-1.6 (EQDP-1.6 in short version) Current Legal Status.

This is basic information in order to know the legal status the respondent

The actions involving a judicial proceeding may vary between countries; however individual countries should adapt these categories according to their legislative frameworks. If the

[2]https://unstats.un.org/unsd/methodology/m49/

[3]https://ec.europa.eu/eurostat/documents/203647/203710/EHIS_wave_1_guidelines.pdf/ffbeb62c-8f64-4151-938c-9ef171d148e0

categories included in the question are not applicable to the legislation and regulations of a country, all the issues should mention in the final comments. All in all, people living in prison can be included in two main legal conditions that apply for most countries.
First the inmates are “Sentenced”, this category includes all people living in prison that were given by a judge, in a law court, a punishment of time in prison after have, officially, been found guilty (convicted) of committing a crime, therefore people with final punishment currently serving prison sentence. The second category is composed of people on remand/pre-trial, the inmates were arrested, charged, defendant (accused formally), remanded in custody, prosecuted (officially accuse in court of committing a crime) awaiting/pending during trial or awaiting sentence after conviction, in a nutshell do not have a final sentence. There is a third category in this question “Held under administrative detention”. This category includes administrative or ministerial procedure under which a person is deprived of liberty, without being charged or formally accused, the person is not in pre-trial detention. No anonymisation rules apply to this variable will remain unaltered.

EQDP-1.7 (EQDP-1.7 in short version) Length of time spent in prison during the current imprisonment.
This is basic information in order to know the prison experience of the respondent
It is a numeric question, with two fields: years and months, that refers to the entire period of imprisonment in all prisons for the current sentence. For those periods shorter than one year, the field “YEAR” should state 0 years and the number of months for the current sentence; in case the period is shorter than one month, the field “MONTHS” should be filled in with the proportion of the month serving the current sentence (e.g. 0.5 for 2 weeks serving the current sentence). No anonymisation rules apply to this variable will remain unaltered.

EQDP-1.8 (EQDP-1.8 in short version) Number of times in prison, excluding the current imprisonment.
This is basic information and allow to have information on prison history of the respondent
This numeric (integer) variable refers to the number of episodes of imprisonment before the current one, regardless of the legal status. It does not refer to the number of correctional facilities. If the answer is “Zero”, refer the respondent to 1.10 Type of offence(s). No anonymisation rules apply to this variable will remain unaltered.

EQDP-1.9 (EQDP-1.9) in short version. Length of the total time spent in prison over lifetime.
This is basic information and allow to have information on prison history of the respondent
It is a numeric question, with two fields: years and months, that refers to the entire period of imprisonment in all prisons *over the lifetime* of the inmate. For periods shorter than one year, the field “YEAR” should state 0 years and the number of months in prison; in case the period in prison is shorter than one month, the field “MONTHS” should be filled in with the proportion

of the month (e.g. 0.5 for 2 weeks in prison). No anonymisation rules apply to this variable will remain unaltered.

EQDP-1.10 (EQDP-1.10 in short version). Type of offence(s) leading to current imprisonment.
This is basic information on legal status and will allow to have information on legal personal history.
This is an optional multi-choice variable. The inmate should place a cross in options Yes/No of each row. Countries should adapt this list of offences to their national legal systems. No anonymisation rules apply to this variable will remain unaltered.

Following UNODC-ICCS[4] classification:

1. Criminal acts against property/heritage are detailed in the Level 4, 5, 7: robbery (0401), burglary (0501), theft (0502), Intellectual property offences (0503), property damage (0504) other acts against property (0509), Fraud (0701).
2. Crimes related "possession/cultivation/purchase of drugs for personal use" are in the Level 6 "acts involving controlled drug or other psychoactive substances": code number 06011.
3. Crimes related to "cultivation/trading/trafficking/distribution/selling drugs" are included in the Level 6 "acts involving controlled drug or other psychoactive substances": code number 06012, 06019, 0602 and 0609.
4. Violent Crimes: are in the Level 01 "acts leading to death or intending to cause death" (excluding 0101321 related to road safety), Level 02 "acts causing harm or intending to cause harm" (excluding those related to road safety, see below), Level 03 "injurious acts of a sexual nature" and Level 08 "acts against public order, authority and provisions of the State",
5. Road safety related offences are in different levels of the classification:
   In Level 01: 101321 Vehicular homicides: inclusion criteria - causing death by dangerous driving; causing death through breach of traffic safety rules; causing death by driving under the influence of drugs or alcohol. In Level 02: vehicular manslaughter: 02063 Negligence related to driving a vehicle; 02072 Operating a vehicle under the influence of psychoactive substances; 020721 Operating a vehicle under the influence of alcohol; 020722 Operating a vehicle under the influence of illicit drugs and 020729 Operating a vehicle under the influence of other psychoactive substances.
6. Other offences are in Level 09 "acts against public safety, and State security", Level 10 "acts against the natural environment" and Level 11 "other criminal acts not elsewhere classified".

[4] https://www.unodc.org/unodc/en/data-and-analysis/statistics/iccs.html

EQDP-1.11 (EQDP-1.11 in short version). Living status –WHERE- before the inmate came into the current prison.

This information help knowing the social condition of the respondent before entering prison.

Treatment demand indicator[5] (standard protocol 3.0) has been used as methodological and theoretical reference in drafting these questions. "The 'where' aspect of living status stresses the stability of the living situation". Inmates in unstable accommodation are inmates who have lived in different places (friends' home, shelters, etc.), moving from one place to another, homeless or sleeping rough in the period prior to prison entry. Stable accommodations are: house, flat, hostel or supported accommodation. If a client is living in a detention institution, he/she should be reported in category "8 others" and the institution specified. The situation refers to the prevailing (most time) situation of the inmate, if he/she is living in more than one context in the same period. The living status refers to the current situation "30 days" before current imprisonment. No anonymisation rules apply to this variable will remain unaltered.

EQDP-1.12 (EQDP-1.12 in short version). Living status –WHOM- before the inmate came into the current prison.

This information help knowing the social condition of the respondent before entering prison

In this question the inmates have to answer "yes" or "no" to each of the categories of the question. The Treatment demand indicator (standard protocol 3.0) has been used as methodological and theoretical references in drafting these questions. The 'whom' aspect of living status indirectly assess her/his social relations and social network. The variable refers to the prevailing situation of the inmate, if he/she was living in more than one context in the same period, referring to the 30 days before entering the current prison. If a client was living in a detention institution, it should be reported in category "8 others". No anonymisation rules apply to this variable will remain unaltered.

1. Nobody - living alone: The inmate is living by his own, unaccompanied by other people, one-person households.
2. Living with the family of origin (parents, etc.): The inmate was living together in the same residence with members of his family.
3. Living with partner / husband / wife. The inmate was living together as partner, husband or wife in the same residence with his/her partner, husband or wife.
4. Adult children (age 18+ years old): The inmate is living in the same residence with adult children, biological and/or non-biological.
5. Dependent children (under 18 years old): The inmate is living in the same residence with dependent children, biological and/or non-biological.
6. Living with friends or other people (not family of origin).

[5] EMCDDA. Treatment demand indicator (TDI) standard protocol 3.0: Guidelines for reporting data on people entering drug treatment in European countries. Lisbon, September 2012. http://www.emcdda.europa.eu/system/files/publications/675/EMCDDA-TDI-Protocol-3.0_392671.pdf

8. Other. The inmate is living with other person/s that was not mention in any of the previous categories. Living with a pet or animals should be considered living with nobody.

In the categories 4 and 5, referring to children the inmate was living with before the current imprisonment. If the inmate answers “yes” to either of these categories “18 or more” or “fewer than 18” years old, the inmate should provide the number of children living with him in the same household. This data is used to assess if the inmate was living with children and what were the living conditions of the inmates and the children. The number of children includes both biological and/or non-biological.

EQDP-1.13 (EQDP-1.13 in short version). Labour status before the current imprisonment.
This information help knowing the social condition of the respondent before entering prison.
This question uses the Treatment demand indicator (standard protocol 3.0) and Eurostat’s standards as methodological and theoretical references to draft the question. Labour status of the inmate provides key information regarding his/her economic and social integration and the inmate daily life. The definition of the categories of this question follows Eurostat official statistics on labour status. No anonymisation rules apply to this variable will remain unaltered.

1. Occasional employed (self-employ or employee): people performing of at least one hour of work (for pay, profit or family gain), during the last 30 days and the job is infrequent, irregular or occurring in scattered instances.
2. Regular employed: people performing of at least one hour of work (for pay, profit or family gain), during the last 30 days and the job is frequent, regular and/or with a written contract.
3. Students (full-time education/training): people attending full-time a school, college, university, etc.
4. Unemployed looking for work/training (person without a paid job): people who are not working and actively looking for a job.
5. Unemployed not looking for work/training (person without a paid job). Discouraged people who are not working and not looking for a job; they are not able to find a job.
6. Social benefits/pensioners or retired/disable employed: These are people who are receiving benefits from social security for their pension or invalidity.
7. Looking after home or family/house-makers. These people are not paid persons managing a household, doing activities within household, cleaning and/or other domestic tasks.
8. Other. The inmate is doing other activities that were not mention in any of the previous categories like volunteering or charity.

EQDP-1.14 (EQDP-1.14 in short version). Highest educational level of the inmate.

This information help knowing the cultural level of the respondent.

This question uses the Treatment demand indicator (standard protocol 3.0) and Eurostat's standards as methodological and theoretical references to draft the question. The categories in the questionnaire are in compliance to International Standard Classification of Education[6] (ISCED), this classification is recommended to facilitate international comparisons of education systems. Countries should implement specific conversion rules to provide education statistics. The answer to this question requires the information about the highest grade or level of school the inmate has completed or, in other words, the highest degree he/she has received. No anonymisation rules apply to this variable will remain unaltered.

1. Never went to school /completed primary school (ISCED 0). The inmate neither did attended school nor completed primary school.
2. Primary level of education (ISCED 1). The inmate completed the primary level of education.
3. Secondary level of education (ISCED 2 - 3). The inmate completer either/both lower Secondary Education (ISCED 2) or/and upper Secondary Education (ISCED 3).
4. Tertiary/Higher education (ISCED 4 – 6). The inmate has completed one or several of the following degrees post-secondary non-Tertiary Education (ISCED 4), short-cycle tertiary education (ISCED 5), bachelor degree or equivalent tertiary education level (ISCED 6), master degree or equivalent tertiary education level (ISCED 7) and/or doctoral degree or equivalent tertiary education level (ISCED 8).
8. Other. For example, if the inmate doesn't remember her/his education level degree and she/he doesn't neither read nor write in the countries' official language mark this option.

[6] https://datatopics.worldbank.org/education/wRsc/classification

Section 2. Substance use outside and inside prison.

Objective of this section is to collect information on substance use both inside and outside prison and it is one of the core objectives of the EQDP. The EQDP collects information on illicit substances and licit substances used in an illicit context/way. As the questionnaire has been developed by EMCDDA, the term DRUG has been chosen for the title of the questionnaire.

One of the main goals of the EQDP is to collect data regarding the use and patterns of use of substances of the people living in prison. Specific goals should include collection of data on use and patterns of use of substances before the person has entered prison (outside) and during imprisonment (inside prison). It is documented (Carpentier, 2018) that the behaviour of people living in prison regarding their substance use may differ "before and after" entering the detention centre. Also, it is relevant to have information on drug market inside prison. It is therefore important to be able to collect information on substance use in the two timeframes. This will also allow to compare the changes in substance use before and during imprisonment.

Therefore, this section includes two parts:

(A) Substance use **OUTSIDE** prison, to collect data related to the use and pattern of use of substances when the inmate was not subjected to the deprivation or restriction of her/his freedom, and

(B) Substance use **INSIDE** prison" to collect data related to the use and pattern of use of substances when the inmate is in custody inside a detention centre serving sentence or on remand (until the trail).

In the Annex 3 a table with some "street" terms for different substance is provided, although this list cannot be considered exhaustive. The names of some products/substances may become obsolete very quickly, since the drug markets, especially online markets, are rapidly evolving.

Terms may also vary between populations, depending on language, geographical area of production, appearance, packaging and logos, drugs culture, prevalent use and practices, etc. Therefore, it is not possible to include all existing street names of each substance. For more detailed information please visit the EMCDDA web site: "https://www.emcdda.europa.eu/publications/drug-profiles and DEA Drug Slang Code Words 2018; https://publicintelligence.net/dea-drug-slang-code-words-2018/

(A) Substance use OUTSIDE prison

EQDP-2.0 (EQDP-2.1 in short version). Have you ever, even if only once, use/consumed substance(s): tobacco, alcohol, illegal drugs or medicines without a doctor's prescription?

(Yes/No).

This is a filter question with the objective to screen people with and without substance use experience.

This is the first question in this section. If the answer of the inmate is "No", should ship all section 2 and 3 and respond to the section "4. Health status". The short version of the questionnaire is restricted to illicit drugs.

EQDP-2.1. Had you ever used any of the following substances, even if only once? Outside prison, before your current imprisonment.

The purpose of the question is to inquire the inmate about her/his experience with substance use during the time the inmate was not living in any detention setting in her/his country or abroad.

The respondent (inmate) should place a cross in, only, one option in each row according to his or her experience. The countries should list substances in their national language and should include any country-specific street names for substances where appropriate. Also, may exclude substances that are not relevant for their national drug markets, bearing in mind that some drugs might be relevant for foreign inmates. For this question, if the inmate has not used any of these substances outside prison skip the question and continue responding the questions in section B.

This question is a table of **two dimensions**: **rows and columns.**

The rows show the list of substances, including legal drugs (tobacco and alcohol), illegal drugs (cannabis, heroin, cocaine, crack, amphetamine, methamphetamine, MDMA…) as well as hallucinogens (LSD, ketamine and mushrooms), other opioids sold in the illegal market (Methadone [without a doctor's prescription as Metasedin], Buprenorphine [without a doctor's prescription as Subutex, Suboxone or Buprex] & Fentanyls [without a doctor's prescription as Alfentanil, Fentanyl or Carfentanil]), hypnosedatives (Barbiturates [without a doctor's prescription as Allobarbital, Pentobarbital or Phenobarbital], Benzodiazepines [without a doctor's prescription as Diazepam –Valium-, Flunitrazepam –Rohypnol- or Temazepam –Restoril-], GHB/GBL, volatile substances[7] (e.g. glues, anaesthetic, solvents, poppers), Anabolic steroids [without a doctor's prescription as Nandrolone or Oxymetholone]. New psychoactive substances (NPS) like synthetic cannabinoides[8] (AKB-48F, JWH-015, UR-

[7] http://www.emcdda.europa.eu/publications/drug-profiles/volatile

[8] http://home.emcdda.europa.eu/html.cfm/index253119EN.html

144…) and synthetic cathinones[9] (Mephedrone, Pentedrone, alpha-PVP, Ethylcathinone…). In the last row the inmate can provide any other substance not included in the previous rows (e.g. Khat, Kraton, BZP or other piperazines, other stimulants as Captagon tables or Amfepramone, other opioids, without a doctor's prescription, as Oxycodone or Tramadol, etc.).

Countries may decide to split the table in more than one table to allow a better understanding and reduce missing values.

The columns show the time period during which the inmate has been using drugs. In the 2017 version the categories were mutually exclusive and exhaustive. However, it was agreed in the last meeting held in Lisbon in January 2020, to change the categories in the 2020 version not avoiding the time overlaps between the prevalence of drug use:

- No use; "Never use any substances".
- Lifetime use; "Substance(s) ever used outside prison before current imprisonment".
- Recent use; in the last 12 months "Substance(s) used during the last 12 months outside prison before current imprisonment".
- Current use in the last 30 days "Substance(s) used during the last 30 days outside prison before current imprisonment".

EQDP-2.2 (EQDP-2.2 in short version). How often have you used the substances listed below outside prison in the last month (last 30 days) before your current imprisonment (!)?

This question aims to understand the substance use patterns of the respondents outside prison.

This question is a table of **two dimensions: rows and columns.**

The rows show the list of substances, including legal drugs (tobacco and alcohol), illegal drugs (cannabis, heroin, cocaine, crack, amphetamine, methamphetamine, MDMA…) as well as hallucinogens (LSD, ketamine and mushrooms), other opioids sold in the illegal market (Methadone [without a doctor's prescription as Metasedin], Buprenorphine [without a doctor's prescription as Subutex, Suboxone or Buprex] & Fentanyls [without a doctor's prescription as Alfentanil, Fentanyl or Carfentanil]), hypnosedatives (Barbiturates [without a doctor's prescription as Allobarbital, Pentobarbital or Phenobarbital], Benzodiazepines [without a doctor's prescription as Diazepam –Valium-, Flunitrazepam –Rohypnol- or Temazepam –Restoril-], GHB/GBL, volatile substances[10] (e.g. glues, anaesthetic, solvents, poppers), Anabolic steroids [without a doctor's prescription as Nandrolone or Oxymetholone]. New psychoactive substances (NPS) like synthetic cannabinoides[9] (AKB-48F, JWH-015, UR-144…) and synthetic cathinones[10] (Mephedrone, Pentedrone, alpha-PVP, Ethylcathinone…).

[9] http://home.emcdda.europa.eu/html.cfm/index253124EN.html

[10] http://www.emcdda.europa.eu/publications/drug-profiles/volatile

In the last row the inmate can provide any other substance not included in the previous rows (e.g. Khat, Kraton, BZP or other piperazines, other stimulants as Captagon tables or Amfepramone, other opioids as Oxycodone or Tramadol, etc.).

The columns show the current frequency of use in the last 30 days for the substances listed in the rows. The categories are the same as in the 2017 version; the categories are mutually exclusive and exhaustive, there are no overlaps:

- Not used in the last 30 days.
- Used on 1-3 days in the last 30 days.
- Used on 4-9 days in the last 30 days.
- Used on 10-19 days in the last 30 days.
- Used on 20 days or more in the last 30 days.

Days versus times.
The frequency of drug use in last 30 days (as indicator of intensity of use).
In the European Model Questionnaire on drugs (EMCDDA, 2020) the frequency of use was operationalized as “number of days of use in last 30 day”. In some previous surveys, it was used the formulation of “how many times used in last 30 days”.
It was considered that “number of times” may lead to different interpretations, in particular considering the translation to different languages. So, users (or in some languages) “times” may be understood as days and in others in actual episodes of use. These differences could have important effects, considering that the question is intended to estimate intensity of use in active users (users in last 30 days). In some cases, the substance can be used several times per day (e.g. marihuana rolls, shared or not shared) or the substance may be used several times in the same using occasion (e.g. cocaine during a long party). The number of days was considered clearer and more specific for comparisons over time and across countries.

(B) Substance use INSIDE prison

EQDP-2.3 During the time you have been inside prison during your current or past imprisonment, have you used the following substances, even only once?

The aim of the question is to inquire the inmate about her/his experience with substance use during the inmate's lifetime within any detention setting in her/his country or abroad.

Each column should be checked (yes or no) according to the inmates' experience. Countries should list substances in their national language and should include country-specific street names for substances where appropriate.

For this question, if the inmate has not used any of these substances inside prison skip the question and continue responding the questions in section 3.

This question is a table of **two dimensions: rows and columns**

The rows show the list of substances, including legal drugs (tobacco and alcohol), illegal drugs (cannabis, heroin, cocaine, crack, amphetamine, methamphetamine, MDMA…) as well as hallucinogens (LSD, ketamine and mushrooms), other opioids sold in the illegal market (Methadone, [without a doctor's prescription as Metasedin], Buprenorphine [without a doctor's prescription as Subutex, Suboxone or Buprex] & Fentanyls [without a doctor's prescription as Alfentanil, Fentanyl or Carfentanil]), hypnosedatives (Barbiturates [without a doctor's prescription as Allobarbital, Pentobarbital or Phenobarbital], Benzodiazepines [without a doctor's prescription as Diazepam –Valium-, Flunitrazepam –Rohypnol- or Temazepam –Restoril-], GHB/GBL, volatile substances[11] (e.g. glues, anaesthetic, solvents, poppers), Anabolic steroids [without a doctor's prescription as Nandrolone or Oxymetholone]. New psychoactive substances (NPS) like synthetic cannabinoides[9] (AKB-48F, JWH-015, UR-144…) and synthetic cathinones[10] (Mephedrone, Pentedrone, alpha-PVP, Ethylcathinone…).

In the last row the inmate can provide any other substance not included in the previous rows (e.g., Khat, Kraton, BZP or other piperazines, other stimulants as Captagon tables or Amfepramone, other opioids as Oxycodone or Tramadol, etc.).

In this question Alcohol use is split about between "alcohol brought into prison" and "alcohol produced within prison", also was included "Strong tea", it refers to a very strong infusion made from tea, sometimes with tobacco or other licit or illicit substances. Each country might replace "Strong tea" with the term used in their own country.

The columns show two measures of drug use inside prison, both are yes/no questions; in the first column the "lifetime of drug use in any prison" and the second the "drug use during the current imprisonment" in any prison".

[11] http://www.emcdda.europa.eu/publications/drug-profiles/volatile

EQDP-2.4 Did you start using these substances for the first time while you were inside prison, either during your current or during any previous imprisonment (!)?

The target of the question is to know if the inmate first experience with substance use took place when the inmate was in custody in any detention setting in her/his country or abroad.

The rows shows the list of substances, including legal drugs (tobacco and alcohol), illegal drugs (cannabis, heroin, cocaine, crack, amphetamine, methamphetamine, MDMA…) as well as hallucinogens (LSD, ketamine and mushrooms), other opioids sold in the illegal market (Methadone, [without a doctor's prescription as Metasedin], Buprenorphine [without a doctor's prescription as Subutex, Suboxone or Buprex] & Fentanyls [without a doctor's prescription as Alfentanil, Fentanyl or Carfentanil]), hypnosedatives (Barbiturates [without a doctor's prescription as Allobarbital, Pentobarbital or Phenobarbital], Benzodiazepines [without a doctor's prescription as Diazepam –Valium-, Flunitrazepam –Rohypnol- or Temazepam –Restoril-], GHB/GBL, volatile substances (e.g. glues, anaesthetic, solvents, poppers), Anabolic steroids [without a doctor's prescription as Nandrolone or Oxymetholone]. New psychoactive substances (NPS) like synthetic cannabinoides[9] (AKB-48F, JWH-015, UR-144…) and synthetic cathinones[10] (Mephedrone, Pentedrone, alpha-PVP, Ethylcathinone…). In the last row the inmate can provide any other substance not included in the previous rows (e.g., Khat, Kraton, BZP or other piperazines, other stimulants as Captagon tables or Amfepramone, other opioids as Oxycodone or Tramadol, etc.).

In this question Alcohol use is split about between "alcohol brought into prison" and "alcohol produced within prison", also was included "Strong tea", it refers to a very strong infusion made from tea, sometimes with tobacco or other licit or illicit substances. Each country might replace "Strong tea" with the term used in their own country.

For each substance should be checked (yes/no/do not know) according to the inmates' experience. Countries should list substances in their national language and should include country-specific street names for substances where appropriate.

EQDP-2.5. Has "your current imprisonment" lasted for at least 30 days (!)?

This is a filter question to understand the length of imprisonment to be related to the substance use.

This is a close question (Yes/No) that is used to filter the number of inmates that have been inside prison for at least 30 days. Those with less than 30 days in custody skip EQDP-2.6 question and continue answering question EQDP-2.7. The data provided in this question should be compared to the data collected in EQDP-1.7 time in prison during the current imprisonment.

EQDP-2.6 (EQDP-2.3 in short version). How often have you used the following substances during the last 30 days inside prison during your current imprisonment (!)?

The question aims at knowing substance use patterns inside prison.

In this question the inmate should cross the value selected in each row according to her/his experience. As in other questions that include a list of drugs, the countries should adapt this list of substances to their national language and should include country-specific street names for substances where appropriate.

This question is a table of **two dimensions: rows and columns.**

The rows show the list of substances, including legal drugs (tobacco and alcohol), illegal drugs (cannabis, heroin, cocaine, crack, amphetamine, methamphetamine, MDMA…) as well as hallucinogens (LSD, ketamine and mushrooms), other opioids sold in the illegal market (Methadone [without a doctor's prescription as Metasedin], Buprenorphine [without a doctor's prescription as Subutex, Suboxone or Buprex] & Fentanyls [without a doctor's prescription as Alfentanil, Fentanyl or Carfentanil]), hypnosedatives (Barbiturates [without a doctor's prescription as Allobarbital, Pentobarbital or Phenobarbital], Benzodiazepines [without a doctor's prescription as Diazepam –Valium-, Flunitrazepam –Rohypnol- or Temazepam –Restoril-], GHB/GBL, volatile substances[12] (e.g. glues, anaesthetic, solvents, poppers), Anabolic steroids [without a doctor's prescription as Nandrolone or Oxymetholone]. New psychoactive substances (NPS) like synthetic cannabinoides[9] (AKB-48F, JWH-015, UR-144…) and synthetic cathinones[10] (Mephedrone, Pentedrone, alpha-PVP, Ethylcathinone…). In the last row the inmate can provide any other substance not included in the previous rows (e.g. Khat, Kraton, BZP or other piperazines, other stimulants as Captagon tables or Amfepramone, other opioids as Oxycodone or Tramadol, etc.).

The columns show the current frequency of use in the last 30 days for the substances listed in the rows. The categories are mutually exclusive and exhaustive; there are no overlaps between categories:

- Not used in the last 30 days.
- Used on 1-3 days in the last 30 days.
- Used on 4-9 days in the last 30 days.
- Used on 10-19 days in the last 30 days.
- Used on 20 days or more in the last 30 days

[12] http://www.emcdda.europa.eu/publications/drug-profiles/volatile

EQDP-2.7. How old were you (in years) (age at first use) when you first used the following substances?

This question aims to know the substance use history of the respondent.

This question should be answered only if the inmate has used the substances regardless of use was outside or inside prison, even if used only once. Otherwise, should skip the question and continue in answering the questions in section "4 Health status". In the question the inmate indicates the age in years for all the substances that has ever used.

This question is a table of **two dimensions: rows and columns.**

The rows shows the list of substances, including legal drugs (tobacco and alcohol), illegal drugs (cannabis, heroin, cocaine, crack, amphetamine, methamphetamine, MDMA…) as well as hallucinogens (LSD, ketamine and mushrooms), other opioids sold in the illegal market (Methadone [without a doctor's prescription as Metasedin], Buprenorphine [without a doctor's prescription as Subutex, Suboxone or Buprex] & Fentanyls [without a doctor's prescription as Alfentanil, Fentanyl or Carfentanil]), hypnosedatives (Barbiturates [without a doctor's prescription as Allobarbital, Pentobarbital or Phenobarbital], Benzodiazepines [without a doctor's prescription as Diazepam –Valium-, Flunitrazepam –Rohypnol- or Temazepam –Restoril-], GHB/GBL, volatile substances[13] (e.g. glues, anaesthetic, solvents, poppers), Anabolic steroids [without a doctor's prescription as Nandrolone or Oxymetholone]. New psychoactive substances (NPS) like synthetic cannabinoides[9] (AKB-48F, JWH-015, UR-144…) and synthetic cathinones[10] (Mephedrone, Pentedrone, alpha-PVP, Ethylcathinone…). In the last row the inmate can provide any other substance not included in the previous rows (e.g. Khat, Kraton, BZP or other piperazines, other stimulants as Captagon tables or Amfepramone, other opioids as Oxycodone or Tramadol, etc.).

The columns show one field for the age at first use of every substance and a second field in case the inmate does not know or remember the age of the first use of the substance.

[13] http://www.emcdda.europa.eu/publications/drug-profiles/volatile

Section 3. Substance injecting and other health risk behaviours.

Objective of this section is to know and understand what are the past and current risk behaviours in substance use of the respondents.

EQDP-3.1 (EQDP-3.1 in short version). Have you ever injected any substance (for non-medical purposes, including anabolic steroids), even if only once, either outside or inside prison?

This is a filter question to know injecting behaviours and ask the following questions. It refers to the illicit use of substances (including anabolic steroids) by injection during the inmates' lifetime and during any imprisonment.

Respondents will only answer this question if they have a history of drug use. The respondents should answer one of the options in each of the rows according to their experience. However, if the answer is yes to at least one of the five questions, the inmate should continue to question 3.2. Otherwise, should avoid 3.2 and skip to question 3.3 (only in the long version).

The five questions are the following:

1. *Injected EVER.*
   Ever injected any substance, for non-medical purposes, including anabolic steroids, even if only once in lifetime, either outside or inside prison.
2. *Injected during last 30 days before CURRENT IMPRISONMENT*.
   Have ever injected any substance during the last 30 days before entering the current prison, for non-medical purposes, including anabolic steroids, even if only once outside prison.
3. *Injected in last 30 days during CURRENT IMPRISONMENT.*
   Have ever injected any substance during the last 30 days during the current prison, for non-medical purposes, including anabolic steroids, even if only once.
4. *Injected ever during ANY IMPRISONMENT. (this option is not in the short version)*
   Haver ever injected any substance, for non-medical purposes, including anabolic steroids, even if only once in any of the prisons where have been in custody in lifetime.
5. *Injected ever during CURRENT IMPRISONMENT.*
   Have ever injected any substance, for non-medical purposes, including anabolic steroids, even if only once in the current prison.
6. *Did your first substance injection happen IN ANY PRISON?*
   The first time that the inmate injected any substance, for non-medical purposes, including anabolic steroids, was in custody inside prison.

EQDP-3.2 (EQDP-3.2 in short version). 3.2 Have you ever shared needles, syringes or other tools used to inject or smoke substances (for non-medical purpose, including anabolic steroids), even if only once?

This question aims to know the risk behaviours of the respondents, namely the share of injecting equipment, including needles and other paraphernalia such as spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc. and hare of smoking material as risk behaviours.

Pipes for smoking are also included. Pipes are made of any material available in prison, these tools are heated and when hot, sharp surfaces can cause cuts and burns to the hands and mouth, also oral inflammation. Blood from injuries may end up on the pipe or other smoking tools. Virus or bacteria contained in the blood can then be transmitted to other inmates using the pipe or smoking tool. A question on the use of shared e-cigarettes, which are used in prisons of some European countries to smoke NPS is also included.

1. *Shared needles/syringes EVER*.
   Ever shared needles/syringes to inject any substance, for non-medical purposes, including anabolic steroids, even if only once in lifetime, either outside or inside prison.
2. *Shared needles/syringes IN ANY PRISON* (this option is not in the short version).
   Haver ever shared needles/syringes to inject any substance, for non-medical purposes, including anabolic steroids, even if only once in any of the prisons where have been in custody in lifetime.
3. *Shared needles/syringes in the last 30 days before CURRENT IMPRISONMENT.*
   Have ever shared needles/syringes to inject any substance, for non-medical purposes, including anabolic steroids, even if only once before current imprisonment.
4. *Shared needles/syringes in the last 30 days during CURRENT IMPRISONMENT*.
   Have ever shared needles/syringes to inject any substance, for non-medical purposes, including anabolic steroids, even if only once in the current imprisonment.
5. *Shared spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc. EVER.*
   Haver ever shared spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc. to inject any substance, for non-medical purposes, including anabolic steroids, even if only once in any of the prisons where have been in custody in lifetime.
6. *Shared spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc. IN ANY PRISON*.
   Haver ever shared spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc. to inject any substance, for non-medical purposes, including anabolic steroids, even if only once in any of the prisons where have been in custody in lifetime.
7. *Shared spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc in the last 30 days before CURRENT IMPRISONMENT.*
   Have ever shared *spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc* to inject any substance, for non-medical purposes, including anabolic steroids, even if only once before current imprisonment.

8. *Shared spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc.in the last 30 days during CURRENT IMPRISONMENT.*

   Have ever shared spoon/cooker, filter, cotton, acid/lemon juice, rinse water, etc. to inject any substance, for non-medical purposes, including anabolic steroids, even if only once in the current prison.

9. *Shared pipes or other equipment for drug smoking EVER*.

   Haver ever shared pipes or other equipment for drug smoking of any substance, for non-medical purposes, including anabolic steroids

10. *Shared pipes or other equipment for drug smoking IN ANY PRISON* (this option is not in the short version).

    Have ever shared pipes or other equipment for drug smoking of any substance, for non-medical purposes, including anabolic steroids, even if only once in any of the prisons where have been in custody in lifetime.

11. *Shared pipes or other equipment for drug smoking in the last 30 days before CURRENT IMPRISONMENT.*

    Haver ever shared *pipes or other equipment for drug smoking of* any substance, for non-medical purposes, including anabolic steroids, even if only once before current imprisonment

12. *Shared pipes or other equipment for drug smoking in the last 30 days during CURRENT IMPRISONMENT.*

    Haver ever shared *pipes or other equipment for drug smoking of* any substance, for non-medical purposes, including anabolic steroids, even if only once during current imprisonment

13. *Shared E-cigarettes for drug smoking EVER.*

    Have ever shared *E-cigarettes for drug smoking of* any substance, for non-medical purposes, including anabolic steroids

14. *Shared E-cigarettes for drug smoking IN ANY PRISON* (this option is not in the short version).

    Have ever shared E-cigarettes for drug smoking of any substance, for non-medical purposes, including anabolic steroids during imprisonment

15. *Shared E-cigarettes for drug smoking in the last 30 days before CURRENT IMPRISONMENT.*

    Have ever shared E-cigarettes for drug smoking of any substance, for non-medical purposes, including anabolic steroids before current imprisonment

16. *Shared E-cigarettes for drug smoking in the last 30 days during CURRENT IMPRISONMENT.*

    Have ever shared E-cigarettes for drug smoking of any substance, for non-medical purposes, including anabolic steroids during current imprisonment

EQDP-3.3 (not in short version). Have you ever been tattooed by someone who was not a professional (licensed) tattooist, including self-made tattoos?

The question aims at knowing tattoos practices as risk behaviour for infectious diseases

1. *Tattooed EVER.*
   Have you ever tattooed by yourself or any other person, even if only once in lifetime, either outside or inside prison?
2. *Tattooed IN ANY PRISON.*
   Have you ever tattooed by yourself or any other person, even if only once in any of the prisons where have been in custody in lifetime?
3. *Tattooed during CURRENT IMPRISONMENT (!).*
   Have you ever tattooed by yourself or any other person, even if only once in the current prison?

Section 4. Health status

Objective of this section is to know the health status of the respondents, particularly related to drug related health problems. Those include drug related infectious diseases and mental health disorders. Those represent a selection of health disorders which may be related to substance use. These questions are of central importance for the identification of the health needs of the respondents with substance use problems.

Questions on HIV and Hepatis, are asked as most frequent reported infectious diseases often associated with injecting drug use. Information on testing, results of tests and interventions are requested. (4.11- 4.14). Questions on TB are also asked.

The objective of these questions is to know whether the respondent has been tested, what were the results of the tests and whether any intervention (treatment, vaccination) has been carried out.

HIV (Same questions in the short version: EQDP-4.1; EQDP-4.2; EQDP-4.3).

- EQDP-4.1. Have you ever had an HIV test outside and/or inside prison?
- EQDP-4.2. Have you ever been infected with HIV?
- EQDP-4.3. Have you ever been treated for HIV outside and/or inside prison?

HBV (Same questions in the short version: EQDP-4.4; EQDP-4.5; EQDP-4.6; EQDP-4.7).

- EQDP-4.4. Have you ever had a HBV (hepatitis B virus) test outside and/or inside prison?
- EQDP-4.5. Have you ever been infected with HBV (hepatitis B virus)?
- EQDP-4.6. Have you ever been vaccinated against HBV (hepatitis B virus) outside or inside prison?
- EQDP-4.7. Have you ever been treated for HBV (hepatitis B virus) outside or inside prison?

HCV (Same questions in the short version: EQDP-4.8; EQDP-4.9; EQDP-4.10)

- EQDP-4.8. Have you ever had a HCV (hepatitis C virus) test outside and/or inside prison?
- EQDP-4.9. Have you ever been infected with HCV (hepatitis C virus)?
- EQDP-4.10. Have you ever been treated for HCV (hepatitis C virus)?

TB (Same questions in the short version: EQDP-4.11; EQDP-4.12; EQDP-4.13; EQDP-4.14).

- EQDP-4.11. Have you ever had a TB (Tuberculosis) test outside and/or inside prison?
- EQDP-4.12. Have you ever been infected with TB (Tuberculosis)?
- EQDP-4.13. Have you ever been vaccinated (BCG) against TB (Tuberculosis)?
- EQDP-4.14. Have you ever been treated for TB (Tuberculosis)?

TB is frequent in detention centre and TB treatment is implemented to control the diseases. As for the other infectious diseases a question for TB testing in the last 12 months for both skin test (Mantoux tuberculin skin test –TST) and blood test (Interferon Gamma Release Assay – IGR) has been included. If the inmate is infected; a "positive" TB test result that means the inmate has TB germs in the body (positive confirmed by chest x-ray). The inmate has been vaccinated (Bacille Calmette-Guerin –BCG vaccine) and the last question regarding the treatment of TB; latent TB infection or active TB disease.
The answer to the questions, related to infectious diseases, should be based on what is reported by the inmates, for both outside and inside prison. This sub-section answers the most common issues about infectious diseases: testing, result of the test and treatment, as well as vaccination of HBV.

Overdose (Same questions in the short version: EQDP-4.15; EQDP-4.16; EQDP-4.17).
These questions have the objective to know whether the respondents have experience overdoses and which were the interventions to manage it.

EQDP-4.15. Have you ever had a substance overdose (a condition after substance use that required professional intervention by a physician or nurse or the attendance of an ambulance) outside or inside prison?
EQDP-4.16. When was your last overdose?
(QDP-4.17. Think back to when you last overdosed on a substance. Where were you when you had the first symptoms?
EQDP-4.17.2. Last overdose; number of days after prison release.
The questions answer common issues about overdose: number of episodes of non-fatal overdose, substances used before the overdose, time and place of the last overdoses and, if the overdose was after prison release, time after being released. The inmates should answer these questions only if they have ever overdosed and responded "Yes" (in option 1 or 2) to question 4.15 (Have you ever had a substance overdose?). Otherwise, the respondent should skip to question 4.18: Mental and emotional problems. The answer should be based on what is reported by the respondent. The question refers to the most recent substance overdose.

Mental Health and emotional problems
(Same questions in the short version: EQDP-4.18; EQDP-4.19; EQDP-4.20; EQDP-4.21).
The following questions aims at knowing the mental health status of the respondents. Mental health disorders are frequent among prison population and in particular among those with substance use problems. (Fazel, 2017).

EQDP-4.18. Have you visited a doctor or treatment centre for mental or emotional problems?
EQDP-4.18.1. If Yes, how many times in the last 12 months?
EQDP-4.19. Have you been prescribed any medication for mental or emotional problems?

EQDP-4.20. Have you ever made an attempt to take your life, by taking substances or self-harm?

EQDP-4.21 How you feel and how things have been with you during the past 4 weeks (past 30 days). Please give the one answer that comes closest to the way you have been feeling.

1. Have you been a very nervous person? (MOS SF-36: Item 24).
2. Have you felt so down in the dumps that nothing could cheer you up? (MOS SF-36: Item 25).
3. Have you felt calm and peaceful? (MOS SF-36: Item 26).
4. Have you felt downhearted and blue? (MOS SF-36: Item 28).
5. Have you been a happy person? (MOS SF-36: Item 30).

Despite the growing concern, mental health is still a problem contributing to health inequalities and suffering. Higher number visits to the doctor may correlate with less life satisfaction of people in prison. Monitoring visits allow assessing people's mental health inside prison. Compared to the previous version of the questionnaire, a question has been added to assess the risk of suicide and another improvement of this version is the addition of the scale of Emotional Well-being of the MOS SF-36 [14].

This scale is the same as the Emotional Well-being scale in the 36-item Short Form Survey (MOS SF-36) adapted by RAND Corporation[15]. The scale has 5 items (24, 25, 26, 28, & 30 in SF-36) to assess people in prison emotional well-being. The scoring rules for this scale are described as follow:

1st step: recoding items to the following values.

Items: 24, 25, 28						**Items: 26, 30**					
1	2	3	4	5	6	1	2	3	4	5	6
0	20	40	60	80	100	100	80	60	40	20	0

2nd step: Averaging items for the scale –Reliability, central tendency and variability.

Scale	**Nº Items**	**Alpha**	**Mean**	**Std. Dev.**
Emotional Well-being	24, 25, 26, 28, 30	0.90	70.38	21.97

In the website of RAND[16] you can find the terms and condition for using the SF-36. The use of the full survey is free and do not need of written permission.

[14] https://www.rand.org/health-care/surveys_tools/mos/36-item-short-form/survey-instrument.html

[15] https://www.rand.org/health-care/surveys_tools/mos/36-item-short-form/survey-instrument.html

[16] https://www.rand.org/health-care/surveys_tools/mos/36-item-short-form/survey-instrument.html

Section 5. Use of health and addiction services.

The objective of this section is to assess the use of health and social services for people in prison with drug related problems. The information from this section help understanding the demand for drug treatment and, in combination with information on substance use and health status, allow to assess the treatment gap in the area of drug problems.

EQDP-5.1 (EQDP-5.1 in the short version). Have you ever attended or are you currently attending drug treatment outside or inside prison?

The question aims at knowing whether the respondent is attending or have attended drug treatment, according to the EMCDDA definition.

For drug treatment it is used the definition provided in the Treatment Demand Indicator protocol Ver-.3.0. Drug treatment is defined in the Treatment demand indicator (TDI) protocol v. 3.0) as any 'activity (activities) that directly targets people who have problems with their substance use and aims at achieving defined aims with regard to the alleviation and/or elimination of these problems, provided by experienced or accredited professionals, in the framework of recognised medical, psychological or social assistance practice. This activity often takes place at specialised facilities for drug/substance users, but may also take place in general services offering medical/psychological help to people with problem substance use'. The definition can be adapted to national needs and situations.

1. *EVER*
   Ever attended any drug treatment, even if only once in lifetime, either outside or inside prison.
2. *Attended any drug treatment in the last 30 days during CURRENT IMPRISONMENT*.
   Have ever attended any drug treatment, even if only once, in the current prison.

EQDP-5.2 (EQDP-5.2 in the short version). Have you used any of the following services in the last 30 days during your current imprisonment (!)?

This question allows assessing the use and availability of drug related services inside prison.

The interventions listed are a selection of the interventions included in the European Facility Survey Questionnaire in Prison (EFSQ-P); the same definitions included in the methodological guidelines for the EFSQ-P are utilised.

Definition of the drug related interventions

Assessment at prison entry – health check-up

It is core and standard practice in prison healthcare when people enter prison. It consists of a medical and psychological examination. The aim of this intervention is to diagnose physical or mental illnesses, provide any required treatment, and ensure the continuation of community medical treatment. Conducting a medical examination on all persons remanded in custody or entering prison after conviction is a core and standard practice in prison healthcare. The health examination should include an assessment of the presence of symptoms of withdrawal from the use of drugs, alcohol or medication. The aim is to diagnose physical or mental illnesses, provide any required treatment, and ensure the continuation of community medical treatment.[17] It usually includes: health check-up, assessment of drug use and drug related problems and assessment of mental health problems.

Opioid Agonist Therapy

OAT is the most common and effective treatment for opioid related disorders. This pharmacological intervention is usually assisted with methadone or buprenorphine. Heroin-assisted treatment may be useful for people who have not responded to other forms of OAT [2]. In some country re-initiation of OAT before the end of the sentence is available in order to reduce overdose risk upon release (Tarjan et al. 2019). The substances most frequently used in opioid substitution treatment in prison are similar to those used in the community in each country.

Detoxification

The process by which an individual is withdrawn from the effects of a psychoactive substance. As a clinical procedure, it includes the medical evaluation of withdrawal symptoms, which may be followed by pharmacological or drug free treatment. Detoxification may be available at prison entry following the health assessment, and at other points further along the prison stay. Most countries in Europe provide detoxification with pharmacological interventions inside prison, mainly with methadone and buprenorphine, although in some countries unspecified non-opioid drugs are used. The modalities of detoxification treatment (requirements, length, forms) differ by country.

Counselling on drug related problems

Behavioural and psychosocial interventions to address psychological and social aspects of drug use include brief interventions, structured psychological therapies, motivational

[17] Adapted from: Prison Insight (EMCDDA, 2020)

interventions, contingency management, and behavioural couple therapy. They are often used in conjunction with pharmacological interventions. [18] Counselling for drug problems may include individual or group counselling.

Individual counselling interventions include needs assessment and care planning, psychological counselling, crisis intervention, motivational programmes, brief interventions, relapse prevention, and harm reduction. Among the common counselling and treatment approaches applied in European countries are motivational interviewing, cognitive–behavioural and socio-educational interventions (e.g. social skills training) [1].

Group counselling interventions include education, information and group therapy. The approaches used may include CBT (Association, 2017) and 12 steps programmes, which can complement individual interventions. Most countries provide group counselling mainly based on an abstinence-oriented approach. The groups use psycho-social techniques, including motivational therapy, coping/social skills training, behavioural self-control training, mutual aid, life skills and family work, with the objectives to address issues such as anxiety, stress, low self-esteem, conflict resolution, social skills, and problematic family relationships [1].

Infectious diseases interventions

People who inject drugs (PWID) constitute a significant proportion of the population who have infectious diseases, particularly HIV and HCV (Wiessing, 2017). These interventions include all interventions for the prevention and treatment of drug related infectious diseases, including HIV, HCV, HBV.

Infectious diseases testing

Routine voluntary and confidential testing with informed consent for HIV, HCV (HBV for unvaccinated) and other infections including tuberculosis, linked to treatment referral and more often than not includes pre- and post-test counselling [2].

During the medical assessment at prison entry, a radiographic examination may be performed if required. ECDC Guidance suggests that early detection of TB may be followed by preventive measures such as isolating a patient during the infectious period to mitigate the risk posed by highly infectious airborne diseases in closed settings (European Centre for Disease Prevention and Control and Addiction, 2018)[1].

Hepatitis B vaccination

Immunisation against hepatitis B for vulnerable individuals[2]. Prison settings may offer a suitable location where vaccination coverage may be increased among individuals belonging to deprived and socially marginalized groups and where specific groups at higher risk, such as people who inject drugs, may be targeted[1].

[18] Adapted from: Health and Social responses guide (EMCDDA, 2017).

TB vaccination

TB vaccination is one of the interventions to prevent infectious diseases, which is very relevant in prison because of the prevalence of TB inside prison and the risk of spreading the infections due to prison living conditions.

Hepatitis C treatment

Hepatitis C (HCV) can be treated using direct acting antiviral (DAA) tablets. DAA tablets are the safest and most effective medicines for treating HCV. They're highly effective at clearing the infection in more than 90% of people. The tablets are taken for 8 to 12 weeks. The length of treatment will depend on which type of HCV you have.
The current standard therapy for hepatitis C consists of pegylated interferon-α (IFN-α), administered once weekly, plus daily oral ribavirin (RBV) for 24 to 48 weeks.

HIV antiretroviral therapy

The treatment of HIV and AIDS with highly active anti-retroviral therapy (HAART) has been scientifically evaluated and can be said that it is effective in the suppression of HIV viral load, the preservation of immunologic function, the improvement of quality of life and the reduction of HIV related mortality and morbidity (Pontali 2005). With the adoption of HAART HIV has lost the life-threatening aspects and has changed into a treatable, chronic disease (WHO 2007, adapted from: Final Report on Prevention, Treatment, and Harm Reduction Services in Prison, on Reintegration Services on Release from Prison and Methods to Monitor/Analyse Drug use among Prisoners – Stöver et al., 2008).

TB treatment

Completion of treatment is important to cure patients and prevent transmission. TB treatment involves taking a combination of drugs for several months. The treatment often causes side-effects and can be costly. Unfinished treatment or non-compliance to the prescribed treatment is problematic as it can lead to drug-resistance. TB patients often face difficulties in adhering to treatment and therefore require patient-centred support to enable them to follow a full course of treatment (ECDC Europe).

Hepatitis B treatment

Treatment for chronic hepatitis B may include antiviral medications, that can help fight the virus and slow its ability to damage your liver.

Needles and syringe exchange

The needles and syringe exchange programmes aim at providing sterile needles and syringes for drug injection as measure to prevent the risk of infection (WHO, 2004) [1].

Disinfecting tablets/bleach

Distribution of disinfectants to clean drug use equipment to reduce the risk of transmission of infectious diseases in the case of sharing equipment among prisoners.

Other sterile material distribution

Provision of injecting equipment: Provision of, and legal access to sterile needles/syringes, and other equipment free of charge, as part of a multi-component approach that includes harm-reduction, counselling and treatment programmes[1].

Overdose prevention/counselling

Effective communication with users can act as a catalyst for reducing harm, as many drug users underestimate, or are unaware of their overdose risks. Ideally, overdose prevention, education and counselling interventions should be routinely provided by trained professionals in health and primary care settings, including harm reduction services, such as needle and syringe programmes. Screening opioid users for overdose risk may reduce overall mortality, while overdose risk assessments can provide early identification of high-risk individuals [2].

Naloxone distribution and training

Naloxone is an opioid antagonist medication used in hospital emergency departments and by ambulance personnel to reverse opioid overdose (EMCDDA, 2016). In addition, training of drug users and others who are likely to witness overdoses, such as family members and hostel workers, on how to recognise and respond to overdoses, combined with naloxone distribution can reduce opioid overdose deaths. People who receive overdose prevention training and learn how to administer naloxone safely and effectively to others can save the lives of those who overdose in their presence. Emerging evidence on the effectiveness of naloxone for intranasal administration is promising and may facilitate use by a wider range of people in the future. People in prison are included in take-home naloxone programmes[2].

Condom distribution

Condom distribution programmes for prisoners are motivated by preventing sexually transmittable diseases. In prisons, condoms shall be easily and discreetly available. Distribution can be carried out by health staff, dispensing machines, trained prisoners (peers) or through a combination of any of these ways. Each prison should determine how best to make condoms available to ensure easy and discreet access. Consistent and correct use of male condoms reduce sexual transmission of HIV and other STIs by up to 94%.

Section 6. Social reintegration and final comments (not included in the short version)

The objective of this section is to gather useful information for assessing the needs of the respondents in the area social reintegration. The questions try to assess selected social needs, including housing and occupation which people will face once they re-entry into society after being released from imprisonment.

People in prison usually comes from precarious social conditions (living and labour conditions) before incarceration. After the prison experience, those needs are in some cases exacerbated. This may be related to an increased risk of recidivism.
No anonymisation rules apply to these two variables, both will remain unaltered.
Specifications: These two are optional question, living availability and where after release.

EQDP-6.1 After release, will you have an address to go to, even if it is only temporary?
EQDP-6.2 After release, which of these situations best describe where you will be living?
These two questions focus on the place of living and the stability (time and quality) of the living situation that the person will have after release from prison.
Inmates in unstable accommodation after release are inmates who will live in different places (friends' home, shelters, etc.), moving from one place to another, homeless or sleeping rough in the period prior to prison entry. Stable accommodations are: house, flat, hostel or supported accommodation. If a client is living in a detention institution, he/she should be reported in category "8 others" and the institution specified.

EQDP-6.3 After release, have you a paid job to go to, even if it is only temporary?
EQDP-6.4 After release, Will you be employed or self-employed?
EQDP-6.5 After release, Will you be working full-time or part-time?
EQDP-6.6 After release, Will this job be temporary or permanent?

These four questions provide information regarding the availability and characteristics of the inmates' job after release, providing key information on her/his economic status.

EQDP-6.7- Additional comments
This question provides the respondents to the chance to express any additional comment, personal opinion, feelings, thought about the situation and her/his life and experience inside prison and the issues included in the current questionnaire.
Please provide any important remarks regarding some questions that were not possible to answer. Also, any other comments would be greatly appreciated (nationality, legal status, health, health services, buying drugs, how drugs are taken, violence in prison, harassment, etc.).

Annex 1 Methodological information

Methodological information	
Method (design)	
Year of data collection	
Number of prisons included / Total number of prisons	
Inclusion and Exclusion criteria	
Sampling method	
Number of prisoners	
Original (Real) sample size	
Data collection mode	
Languages available	
Method of survey administration	
Setting of survey delivery	
Time of administration of each questionnaire	
Total cost	
N. of staff involved in the survey research staff, health staff, prison staff, other	

Annex 2 – Informed consent (example)

INFORMED CONSENT

Principle Investigator, Affiliation and Contact Information:
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Introduction and Purpose of the Questionnaire

The European Questionnaire on Drug Use among people in Prison (EQDP) concerns your drug use **before entering prison and during your stay in prison** (currently or during a previous imprisonment). The purpose of the questionnaire is to collect information that can be used **to improve health, social services and facilities for people living in prison** to ultimately have better physical, psychological and social conditions. The objective is from a **public health perspective** with the goal to improve the health of the **whole community**.

Subject Participation

All people living in prison are eligible to participate in this study. You will be asked to complete only one single questionnaire, which will take approximately 1 hour in length. The analysis of your answers by the researcher in charge of data analysis will improve our **knowledge about drug use in prison, and the health and social situation in prison**. A better knowledge of the current situation will help to develop and implement measures that reduce risks related to drug use and improve the health of people living in prison.

Potential Risks and Benefits of Participation in the Study

There are no known risks of participation in the study. Your information provided through the questionnaire is confidential and no personal information will be associated with your answers. Benefits are related to an improvement of knowledge regarding the current situation of drug problem that enable an improvement of measures to reduce risks and improve the conditions of people living in prison.

Guarantees for the participants: Voluntary participation, anonymity and confidentiality

Your participation in this survey is completely **voluntary, anonymous and confidential** - you are free to choose whether or not to participate without any consequences for you. If you decide to not participate in this study, it will not affect the care, services, or benefits to which you are entitled. If you decide to participate in this study, there is no way to identify you (anonymous) and your answers will be protected and treated exclusively by the researcher responsible for the survey. Moreover, you may **withdraw from your participation at any time** without penalty.

The data **will not be transmitted** to the Penitentiary Administration.
The investigator(s) will safely keep all files and data collected in a secured locked cabinet in the principal investigators office. Your questionnaire (paper version) filled in with answers will be destroyed two years after the date indicated on the questionnaire. Its anonymous electronic version will be fully deleted 10 years after the date indicated on the questionnaire**. The confidentiality of your answers will be guaranteed.**

If you need any **assistance in the completion of this questionnaire, please do not hesitate to contact** the reseacrher responsbile for the survey. A health professional or research assistant will be available to answer your questions and help you.

Further information about data protection

The study is fully in line with the European Data Protection Regulation Regulation (EC) No 2018/1725 and Decision No 1247/2002/EC[19]. No personal identifying information or IP addresses will be collected. Only **completely anonymous and fully aggregated results** of the study will be **published.** (References to weboste or publication are provided)
If you require any further information or have any further questions regarding data protection, you can send a written communication to the following address :
European Data Protection Supervisor edps@edps.europa.eu
European Monitoring Centre for Drugs and Drug Addiction Data Protection Officer DPO@emcdda.europa.eu
National Data Protection Authorities (of the country that is carrying out the survey)

By participating in this completely anonymous and voluntarily survey, I consent to my data being recorded and processed and agree to the analysis of my responses for epidemiological monitoring purposes.

Date

……

Signature

……

We highly appreciate the time you provide for completing this questionnaire and thank you for your participation!

[19] Regulation (EU) 2018/1725 of the European Parliament and of the Council of 23 October 2018. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32018R1725&from=EN

Annex 3- Street names of substances that may be used in prison (some examples)

Substance	Street names
1. Cannabis	Herbal cannabis and cannabis resin are formally known as marijuana and hashish (or just 'hash') respectively. Cannabis cigarettes may be termed reefers, joints or spliffs. Street terms for cannabis/cannabis resin include bhang, charas, pot, dope,
2. Powder cocaine	Coke, snow
3. Crack cocaine	Base, rock
4. Amphetamine	Speed, whizz
5. Methamphetamine	Meth, crank, Ice, crystal meth, pervitin (particularly in eastern Europe; a name derived from an earlier medicinal product), yaba and shabu (certain countries in the Far East).
6. Ecstasy (MDMA or MDA)	Adam and XTC, but often reflect the imprinted logo, e.g. Mitsubishis, Love Doves
7. Hallucinogenic mushrooms	Shrooms; magic mushrooms; sacred mushrooms; teonanácatl. Forms of psilocybin and psilocin or mushrooms containing these hallucinogens: blue caps, boomers, booms, buttons, caps, champ, fungus, funguys,
8. Ketamine	K, special K
9. LSD (acid, dots)	Acid, dots, blotters, tabs, tickets, trips.
10. Heroin	Horse, smack, shit and brown.
11. Methadone misused*	Done,.metha,
12. Buprenorphine misused*	Bup, B, subs, bupe
13. Fentanyl illicit/misused*	China White, Synthetic Heroin, Drop Dead, Flatline, Lethal Injection, Apache, China Girl, Chinatown, Dance Fever, Great Bear, Poison, Tango & Cash, TNT, Pers e Pops and Lollipops
14. Barbiturates misused*	Barbs, downers, Christmas trees, blue heavens, blues, goof balls, blockbusters, pinks, rainbows, reds, red devils, reds and
15. Benzodiazepines misused*	Benzos, blues/blueys, tranx, roche's, mother's little helpers, duck eggs (temazepam), roofies (Rohypnol®)
16. GHB/GBL	G, Liquid X
17. Volatile inhalants/solvents	Glue sniffing, dusting, chroming, poppers (Alkyl nitrites)
18. New psychoactive substances:	Spice, fake weed
19. New psychoactive substances: synthetic cathinones (e.g. mephedrone, pentedrone, alpha-	Mephedrone: M-Cat, meph, drone, miaow, meow meow, subcoca-1 and bubbles. Methylone: Top Cat
20. Anabolic steroids	Juice, gym

Annex 4 - Checklist of recommendations for the implementation of the EQDP

Areas of the questionnaire	Recommendations
Aim of the survey	Public health, NOT control.
Survey management	The survey should be carried out by institutions that are independent of the prison setting.
Stakeholders involved	National stakeholders in public health, justice and drug policy.
Existing tools and resources	Existing tools and resources should be reviewed and considered before creating/using new instruments and resources.
Data collection form	European Questionnaire on Drug Use among people living in prison (EQDP).
Priority areas of the EQDP	Priority 1, sections 1, 2 and 3 (General information, Drug use outside and inside prison, Drug injecting) — minimum standard; priority 2, sections 4 and 5 (Health status, Use of health and addiction services).
National adaptation of the EQDP	Some questions might not be relevant for every country; others might be too sensitive in some countries, especially those referring to current imprisonment, which are marked with an exclamation mark: (!). One or more of these questions may be omitted.
Other sources	Triangulation of the results with other sources of information on drug use and health among people living in prison is crucial for surveys in prisons.
Terminology and language	Should take into account the specificity of the prison environment (e.g. in relation to high levels of illiteracy). Where the prison population includes large groups of foreigners, this must be taken into account. Close collaboration between countries facing similar problems is desirable (e.g. on translation of questionnaires).
Ethical standards	Ethical issues should be carefully considered. Set up or consult an ethical board. An informed consent should be obtained from respondents (see a possible model in the annex)
Design	Cross-sectional survey.
Periodicity	Every two years; a maximum interval of four years between surveys is recommended.
Target population	All people living in prison on a given day or during a given week in all custodial institutions (the minimum standard is those serving a sentence).
Access to prisons	Establish or reinforce connections with the ministry of justice and/or the prison administration.

Areas of the questionnaire	Recommendations
Sampling	The sample should be representative of the entire prison population. Some groups — for example women people living in prison, juvenile detainees, young adult offenders, foreigners or others — may be deliberately over-represented, depending on the country in question.
Introduction to the interview	Inform all participants about the benefits of the survey, their rights, and how anonymity and confidentiality will be ensured.
Individual rights of the participants	Any participant may decline to take part in the survey; this decision must not entail any sanction for the person.
Anonymity and confidentiality	Participation in the survey and the data it provides must be strictly confidential. Setting rules and conditions to guarantee anonymity is essential and it is not sufficient to state that the survey will be anonymous. No names or numbers of people living in prison should appear in any of the survey documents.
Non-response	Information on non-response should be collected in order to control for bias.
Data collection methods	Priority 1: self-administrated questionnaire (pen and paper or CAPI); priority 2: face-to-face interview. There is no obligation to use a particular method, but priority 1 is strongly recommended.
Data management	This should be planned in advance, indicating decisions on the following: data format, who should enter data, which software should be used, double-counting measures, internal validity check, etc. (special attention should be paid to the values ‘zero’ and ‘empty fields’ in numerical variables).
Missing values	Implement strategies to reduce and code for missing values.
Documentation	The overall procedures used in the implementation of the survey and subsequent data management need to be clearly documented.
Data quality	Measures to ensure data quality should be applied in every phase of the survey, from data collection to data management and analysis.

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