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THE HARMS OF INCARCERATION

The evidence base and human rights framework for decarceration and harm reduction in prisons

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Highlights

REDUCING INCARCERATION WILL REDUCE HARM

One in five people in prison worldwide is held for drug offences, and 90% of people who inject drugs will be incarcerated at some point in their life. People in prison are at greater risk of HIV, hepatitis C, tuberculosis and COVID-19. When they are released from prison, their risk of overdose increases by up to 69-times.

States must support people to live healthy lives by not putting them in prison and by promoting alternatives to incarceration.

PROVIDING HARM REDUCTION IN PRISONS IS A HUMAN RIGHTS OBLIGATION

People in prison retain their human rights, which includes their right to health. By withholding health services such as harm reduction from them, states are violating this right. In some cases, withholding essential services like opioid agonist therapy amounts to torture. The UN Special Rapporteur on Health, the European Convention on Human Rights, and the Nelson Mandela Rules on the treatment of prisoners all oblige states to provide health services in prisons.

States must provide harm reduction in prisons to meet their human rights obligations.

HARM REDUCTION IN PRISONS IS AN EFFECTIVE AND SAFE PUBLIC HEALTH MEASURE

Harm reduction works. Robust evidence shows that harm reduction services reduce transmission of HIV and viral hepatitis, reduce risk behaviours, reduce deaths from all causes, and can even reduce chances of people coming back to prison. This is why the World Health Organisation, UNAIDS and UN Office on Drugs and Crime all support harm reduction in prisons.

States must protect the health of people who use drugs by providing harm reduction services in prisons.

PEOPLE IN PRISON ARE SEVERELY UNDERSERVED BY HARM REDUCTION SERVICES

Even though states are obliged to provide the same standard of healthcare inside and outside prisons, when it comes to harm reduction, they do not do so. In nearly a third of countries where opioid agonist therapy is available, people in prison have no access. In 88% of countries where needle and syringe programmes operate, there are none in prisons. Even where services are available in prisons, there are frequently barriers that make them inaccessible in practice.

States must ensure that harm reduction services are available and accessible in prisons.

Reducing incarceration will reduce harm

Over 11 million people are imprisoned worldwide today, the highest number ever recorded.[1] Globally, the dominant response to drugs remains prohibition-based drug policies backed by criminal sanctions that have contributed to the increase in the prison population.

Despite some moves towards the decriminalisation and regulation of drugs, drug offences remain one of the biggest drivers of incarceration. At least one in five people in prison globally is held for drug-related offences.[1,2] Approximately half a million people are serving sentences for personal drug possession.[3] UNAIDS estimates that up to 90% of people who inject drugs will be incarcerated at some point in their life.[4] There are also more than 400,000 people detained in forced rehabilitation and compulsory drug detention centres in Asia alone, with forms of compulsory drug treatment also existing in Latin America and the Caribbean, Eastern Europe and Central Asia and elsewhere.[5] This punitive approach has the greatest impact on already marginalised populations, including women, racial and ethnic minorities, indigenous people and foreign nationals.[2]

Incarceration is also an enormous waste of money and resources. Over USD 100 *billion* is spent globally on drug law enforcement every year, but just USD 131 million was spent on harm reduction in low- and middle-income countries in 2019. This means that **we spend more than 500 times the amount on punitive responses than we do on life-saving services for people who use drugs.**[6–8]

Systematic reviews of evidence find that there is no clear link between imprisonment and crime rates or between compulsory treatment and drug use.[9,10] In fact, there is more evidence for links between reduced welfare systems and social inequality, and increased imprisonment rates.[3,9,11] Nevertheless, in many countries, and even more so in the context of a surge of oppressive regimes in many parts of the world, the punitive "lock them up" response to drugs remains the easiest answer to a complex issue.

PEOPLE IN PRISON NEED HARM REDUCTION SERVICES

According to global statistics, people who use drugs make up about one-third to one-half of the world's prison population.[12] The use of drugs in closed settings should come as no surprise. People in prison require access to harm reduction services. In fact, the increased risk of overdose, HIV, viral hepatitis and tuberculosis in closed settings means that harm reduction interventions have even greater potential in prisons.

In European countries, between 2% and 55% of people in prison reported injecting drugs while incarcerated.[13] Not only is injecting drug use documented in prisons in every region of the world, but studies demonstrate that people in prison are much more likely to share injecting equipment than those outside.[12,14] This, alongside overcrowding, poor hygiene standards and low quality and inaccessible health services make prisons places where infectious diseases spread easily.[15] Sharing injecting equipment has been linked to outbreaks of HIV in prisons in Iran, Lithuania, Thailand, the United Kingdom and Ukraine.[12] Globally, 3.2% of prisoners are living with HIV and 15.1% are living with hepatitis C, figures which far outstrip prevalence in the broader community, and prevalence among people who inject drugs in prison is even higher.[16]

It is not just about infections. People in prison are also disproportionately vulnerable to overdose, both during their sentence and immediately after their release. Studies show that male and female prisoners are 19 and 69 times more likely, respectively, to die from an overdose than the non-prison population, with the first two weeks following release identified as particularly dangerous.[17–19] This may be related to a decrease in tolerance, drug purity variations, and changes in drug use behaviour.

RACE, INCARCERATION AND DRUG POLICY

In a 2015 study on the impact of drug laws on human rights, the UN High Commissioner for Human Rights acknowledged that people of colour "may be particularly subject to discrimination in the context of drug enforcement efforts."[20] The evidence for this is clear. Globally, the criminalisation of drugs perpetuates injustice, and people of colour are discriminated against at every stage of the judicial process.

In the United States, Black people are over three times more likely to experience arrest for drug offences by the age of 29 than white people.[21] This pattern is repeated around the world: in South Africa, stop-and-search campaigns disproportionately target Black communities, and in the Western Cape 'coloured' citizens are more than twice as likely to be arrested for drug possession than other racial groups.[22] In the United Kingdom, Black people are stopped and searched for drugs at nine times the rate of white people, despite the 'find' rate for drugs being lower among Black people than white people.[23]

Racial disparities in sentencing for drug offences mean that people of colour are not only incarcerated more often, but also for longer sentences. In Brazil, Black people are more likely to be sentenced for drug trafficking, rather than possession, with only 5% of trafficking cases downgraded to possession compared with 50% for white people.[24] In the United Kingdom, the chance of receiving a prison sentence in a drug case is 240% higher for people of colour compared with white people.[25]

As a result of racial disparities in policing and sentencing, Black men are incarcerated at five times the rate of white men in the United States, and more than one third of all federal prisoners are Black, despite comprising only 13% of the population, meaning their representation is almost three times that in the general population. In Australia and New Zealand, incarceration rates for Indigenous groups are vastly higher than for the white population. In Australia, Aboriginal and Torres Strait Islander people make up 3% of the population, but 28% of the prison population; in New Zealand, Māori people are 16.5% of the population but 52% of the prison population. [26–28]

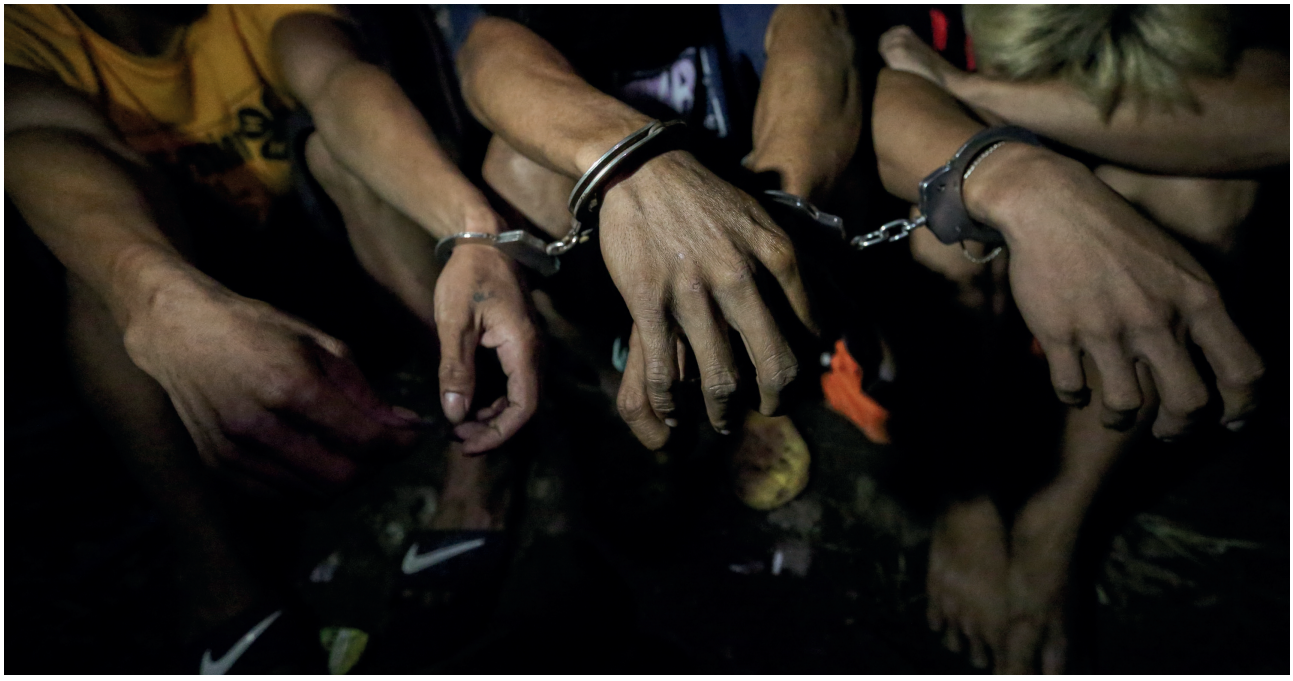

Photo: Raffy Lerma

Harm reduction in prisons is a human rights obligation

Under international human rights law, persons deprived of their liberty retain all fundamental rights and freedoms, apart from those that are unavoidably restricted by the fact of their incarceration.[29] Therefore, people in prison have a right to health, like everyone else. The **Nelson Mandela Rules** (aka the UN Standard Minimum Rules for the Treatment of Prisoners) state that people in prison must have access to the **same standard of care as they would outside prison**, and that health services must ensure continuity of treatment including for drug dependence.[30]

In closed settings, the right to health and the right to freedom from torture and ill treatment are interdependent: denying people's right to health can amount to torture.[31] Several international and regional human rights mechanisms clarify states' obligations to provide essential health services to people who use drugs in prisons. For example, the **UN Special Rapporteur on the Right to Health** has recognised the provision of harm reduction in prisons as a legally binding obligation under the right to health on several occasions.[32] In 2016, the **European Court of Human Rights** ruled that denying OAT to people in prison is a violation of the **European Convention on Human Rights'** prohibition of cruel, inhuman and degrading punishment.[33]

More broadly, the **UN Working Group on Arbitrary Detention** has recognised that **over incarceration for drug-related offences** contributes significantly to prison overcrowding. In its 2015 report, the same Working Group stated that compulsory detention for drug "rehabilitation" is contrary to scientific evidence and inherently arbitrary. **Involuntary confinement of those who use or are suspected of using drugs must be avoided.**[34] The **UN Common Position on Incarceration** also calls for a reduction in the use of incarceration, as well as the expansion of health programmes for people who use drugs in prison.[35]

Overall, the **UN Common Position on Drugs** calls for the **decriminalisation of drug possession for personal use**. This is endorsed by the Chief Executives Board for Co-ordination which represents all 31 UN agencies including the UN Office on Drugs and Crime, the World Health Organisation and the UN Development Programme.[36,37]

Photo: Rafiy Lerma

COVID-19: A MISSED OPPORTUNITY TO ADDRESS OVERCROWDING AND PRISON REFORM

The COVID-19 crisis has spotlighted the public health dangers of overcrowding in prison and detention facilities, which are even in normal times high risk environments for the spread of infectious diseases. When COVID-19 was identified as a global pandemic in March 2020, the Office of the High Commissioner for Human Rights, the UN Special Rapporteur on the Right to Health and several international organisations called on states to enact emergency measures to address and contain the spread of COVID-19 in prisons and other closed settings.[38,39] Data is lacking, but there is evidence that prisoners have been underserved by prevention, testing and vaccination efforts.[40]

A global network of 300 organisations highlighted the contradiction between overcrowding in prison and detention facilities and the physical distancing prevention measures forced by COVID-19. Prisons, as well as compulsory treatment centres and private drug treatment centres, were putting the health and lives of those detained in danger.[41] Governments were called to limit arrests, promote alternatives to punishment and incarceration, and urgently release prisoners with underlying health conditions, older persons, and those charged or convicted for minor or non-violent offences, including drug offences, as well as to release people from compulsory treatment centres.[42]

Despite these calls, Harm Reduction International's monitoring of prison releases between March and June 2020 found that "around a fourth of countries implementing decongestion schemes explicitly excluded people incarcerated for drug offences; effectively prioritising punitive approaches to drug control over the health of the prison population and the individual". The 6% global reduction of prison population allowed by decongestion schemes fell well short of expectations and the political commitments made in the name of public health. [43]

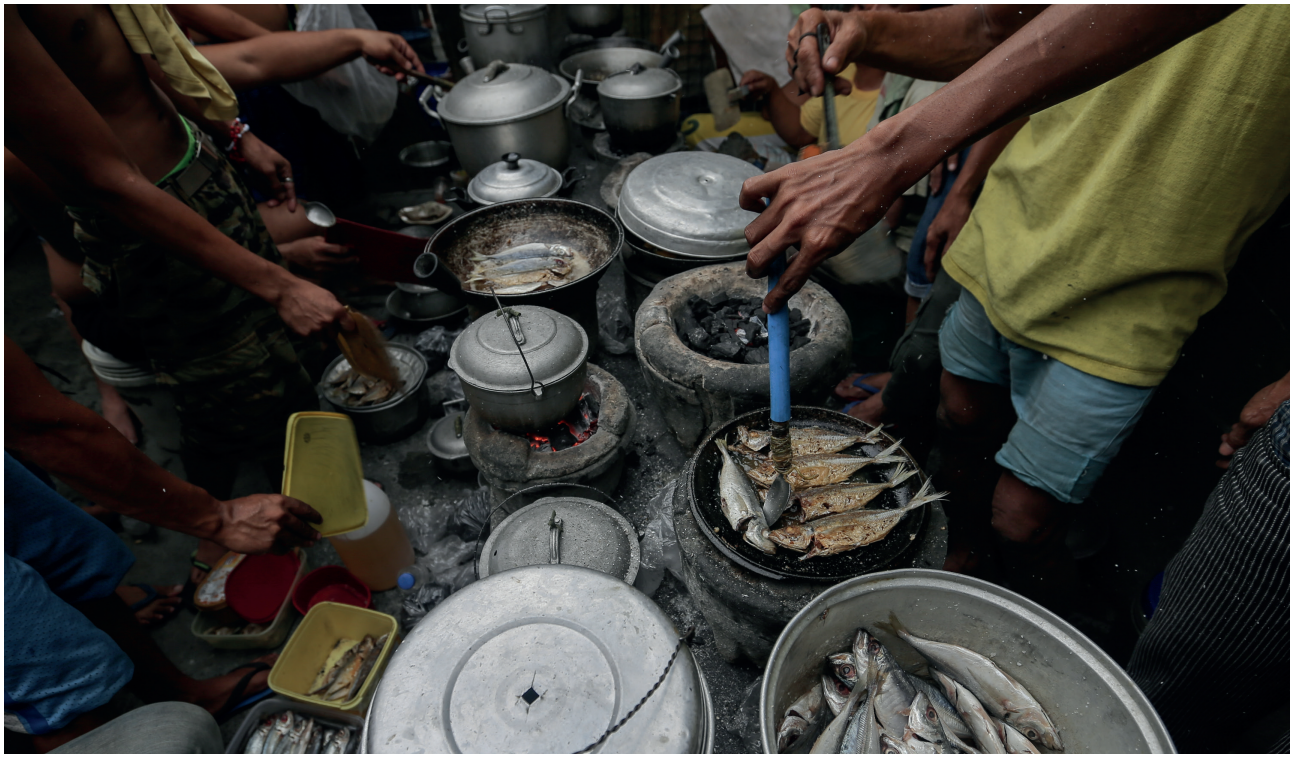

Photo: Raffy Lerma

Harm reduction in prisons is effective, safe and evidence-based

The **World Health Organization, UNAIDS, UN Office on Drugs and Crime, International Labour Organization and UN Development Programme** all recommend the implementation of harm reduction in prisons and other closed settings as essential public health measures.[44] The **Outcome Document** of the 2016 UN General Assembly Special Session on the World Drug Problem **urged states to provide harm reduction services**, including NSPs, OAT, naloxone and treatment for HIV and viral hepatitis.[45]

There is a reason these institutions are firmly in favour of harm reduction programmes in prisons: the evidence shows us that they work.

OPIOID AGONIST THERAPY (OAT)

Systematic reviews show that access to OAT in prison **reduces illicit opioid use and risk behaviours** like injection and needle sharing, which, in turn, leads to **a reduced risk of HIV, viral hepatitis and tuberculosis** transmission.[46,47] Notably, it is less effective when doses are lower, showing the importance of adequate dosage when prescribing OAT. Systematic reviews also show that OAT is important in the transition between prisons and the wider community. Disruption of OAT when entering prison is associated with an increase in hepatitis C incidence, while **pre-release OAT is associated with retention in OAT after release**.[46] There is also some evidence in systematic reviews that enrolment in prison OAT makes **clients less likely to re-enter prison** - a finding supported by observational studies in Canada, France and the United States.[46,48–50]

A 12-year cohort study in Australia found that there was a 74% **reduction in all-cause mortality** among people enrolled in prison OAT, and an 87% reduction in suicide, violent or overdose deaths.[51] A similar study in England had almost identical findings: a 75% reduction in all-cause mortality and an 85% reduction in overdose deaths in the first month after release.[52]

NEEDLE AND SYRINGE PROGRAMMES (NSPS)

Several reviews of evidence have shown that prison NSPs **reduce transmission of viral hepatitis and HIV**, to the extent that they find no evidence of any transmission through injecting drug use in prisons where an NSP is operational.[15,53,54] Reviews and observational studies have demonstrated the link with NSPs and a **reduction in risk behaviours**. For example, the proportion of people who had ever injected drugs reporting syringe sharing in prison fell from 20% to 8% after the introduction of a prison NSP in Kyrgyzstan.[53,55] All this is achieved with no evidence of syringe-related violence where prison NSPs are in operation.[15,53,54] The most extensive study of a prison NSP was a ten-year study in Ourense, Spain. It found that more than 15,000 syringes had been distributed, alongside reductions in HIV and hepatitis C prevalence, no increase in injecting drug use, no syringe-related violence, and that prison staff who had initially been sceptical were satisfied that the project was beneficial.[56]

NALOXONE

Systematic reviews demonstrate that take-home naloxone programmes reduce mortality from opioid overdose, making a strong case for the distribution of naloxone to high risk groups like people released from prison.[57] Evaluations of such naloxone-on-release programmes bear this out. In Scotland, an evaluation found a 50% **reduction in overdose deaths** after the introduction of the programme,[58] while in San Francisco, United States, 32% of people who received naloxone reported using it to reverse an overdose.[59] These programmes are also effective at engaging and **educating new clients on overdose risks and response**: in San Francisco, 97% of participants had never been trained in naloxone before,[59] and in Norway the programme improved knowledge of risk factors, symptoms and care for opioid overdose.[60] This is accompanied by evidence from two studies in Australia that both people held in prison and prison staff are accepting of and willing to participate in take-home naloxone programmes.[61,62]

The state of harm reduction in prisons: Availability does not mean accessibility[1]

OPIOID AGONIST THERAPY (OAT)

84 countries provide OAT
59 provide OAT in prisons

In many countries, only a few prisons offer OAT, for example Afghanistan, Belgium, Indonesia and Vietnam. In larger or federal states, availability of OAT can depend on the jurisdiction. For example, in Germany, only one person in prison in 2019 reported receiving OAT in the state of Saxony, while more than 1,000 received OAT in prisons in Berlin. In Canada and the United States, there is a significant difference between what is available in federal and state, provincial or territorial prisons.

Even where OAT services are formally available, accessibility remains a significant problem. For example, in the whole of Ukraine only 93 people in prison are enrolled in OAT. The most widespread formal barrier to access is the inability to initiate OAT in prison, including in Albania, Cyprus, Jordan, Latvia, Lebanon, Montenegro, Morocco and Serbia. Unfounded fears of diversion of medication, as well as stigma and negative attitudes towards people who use drugs, are also reported as barriers to access, including in Canada, Germany and Italy.

NEEDLE AND SYRINGE PROGRAMMES (NSPS)

86 countries provide NSP
Only **10** provide NSP in prisons

Within the 10 countries where NSPs operate in prisons, they are rarely available in all prisons. In Canada, there are NSPs only in 11 of 44 federal prisons and none in the provincial or territorial prisons that represent 60% of prison capacity in the country. In Germany, there is only one syringe-dispensing machine in one women's prison facility in Berlin.

In prisons where NSPs operate, there are significant barriers to their effective implementation as health services, often as a result of a 'zero tolerance' mentality of prison staff towards drug use. In Canada and Spain, these include limited confidentiality, long waiting lists, lack of awareness of the programme, inappropriate or inadequate injecting equipment, and cell inspections that penalise the possession of altered or damaged equipment acquired from the NSP.[63]

The world's first prison drug consumption room (DCR) opened in Alberta, Canada in 2019. While the introduction of DCRs in prison is commendable, it is not a replacement for an effective NSP.

NALOXONE

Harm Reduction International found no reports of naloxone being made directly available to people in prison. Availability of naloxone to prison staff depends not only on the country, but also on sub-national jurisdictions and even individual prison authorities. Few countries implement naloxone-on-release programmes.

With the exception of Estonia, programmes providing naloxone doses and training on release are not systematic or present in all prisons. For example, in England, the programme only operates in 51% of prisons and only 11% of prisoners with a history of opioid use are enrolled. Even in Estonia, accessibility remains a concern. Those eligible must specifically request to participate but many choose not to because of a perceived risk that they will be denied parole if they show an intent to use drugs once they are released.

HIV, VIRAL HEPATITIS AND TUBERCULOSIS TREATMENT

Viral hepatitis, HIV and tuberculosis testing and treatment are generally available in prison if they are widely available in the community. Access to hepatitis C care is more limited, and in some contexts can depend on the prison in question. For example, in Hungary, Mexico and Ukraine, less than half of prisons offer hepatitis C treatment, despite treatment being available outside prisons.

Where treatment is available, there are commonly barriers to access. In Canada, prison health services are commonly provided by the federal, provincial or territorial correctional authority, rather than the relevant department of health. This risks damaging the equivalence of care between prisons and the broader community. Other barriers include financial barriers related to insurance and reimbursement of costs in Belgium and Switzerland, as well as long bureaucratic processes related to the continuation of treatment on entering prison in Italy.

1 All data in this section, unless otherwise stated, is from Harm Reduction International's *Global State of Harm Reduction 2020*.[5]

Redressing the balance: Human rights, punitive approaches and neglect

The criminalisation of drug use and possession and disproportionate criminal penalties for all drug offences result in the over-representation of people who use drugs in detention settings. The global 'war on drugs' has failed to prevent the production, trafficking, and use of drugs. On the contrary, there is now plenty of evidence to show that the pursuit of a drug-free world has created far more harm than the drugs themselves.[64]

People deprived of their liberty retain their human rights, including their right to the highest attainable standard of health. Fulfilling the right to health includes ensuring access to preventive health services and harm reduction services, such as OAT and NSPs, for all who require it, including in prison settings.[65]

Human rights violations occurring as a consequence of drug control, enforcement and deprivation of liberty have been a growing concern and progressively more attention is being paid on the balancing of concomitant obligations within the drug control and human rights international legal frameworks.[66] **This was bolstered by the publication of the International Guidelines on Human Rights and Drug Policy in 2019.**[67] Constant attention, multi-level advocacy and independent monitoring are key elements for both human rights and drug policy reform advocates, in order to ensure that the destiny of the many facing imprisonment is not overlooked.

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