Joint Submission to the Special Rapporteur on Health report on Drug policies and responses: a right to health framework on harm reduction

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Submitting organisations:

Harm Reduction International (HRI) is a leading non-governmental organisation that envisions a world in which drug policies uphold dignity, health, and rights. We use data and advocacy to promote harm reduction and drug policy reforms. We show how rights-based, evidence-informed responses to drugs contribute to healthier, safer societies, and why investing in harm reduction makes sense.

HRI is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

European Prison Litigation Network (EPLN) is an international NGO holding a participatory status with the Council of Europe, which focuses its activities on enhancement of the judicial protection of the fundamental rights of prisoners in the Member States of the Council of Europe. It currently brings together 25 national NGOs and bar associations from 18 Council of Europe Member States

Health Without Barriers (HWB) - the European Federation for Prison Health, brings together national-based independent scientific societies and associations of medical professionals, in order to promote health and human rights in European prisons, for the benefit of the entire population. HWB aims at improving prisoners' health and detention conditions, through the promotion of good health practices, ethical standards for the protection of human rights in prison, research, and interdisciplinary collaboration in the prison field.

Penal Reform International (PRI) is a non-governmental organisation working globally to promote criminal justice systems that uphold human rights for all and do no harm. We work to make criminal justice systems non-discriminatory and protect the rights of disadvantaged people. We run practical human rights programmes and support reforms that make criminal justice fair and effective.

PRI enjoys ECOSOC Special Consultative Status since 1993. Registered in The Netherlands (registration no 40025979), PRI operates globally with offices in multiple locations.

The **"Promo-LEX"** Association is a civil society organization with special consultative status with the UN (ECOSOC) based in Chisinau, whose purpose is to advance democracy in the Republic of Moldova through promoting and defending human rights and monitoring democratic processes. Promo-LEX was founded in 2002 and is based in Chisinau. Promo-LEX works through the Human Rights Program and the Monitoring Democratic Processes Program

UnMode is an international non-governmental organization with a network nature. Geography of representation: countries of the region of Central and Eastern Europe and Central Asia. UnMode's mission is to ensure access to justice as an effective human rights tool for prisoners/ex-prisoners with a history of drug use in the region.

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Introduction

Harm Reduction International (HRI), European Prison Litigation Network (EPLN), Health Without Barrier (HWB), Penal Reform International (PRI) Promo-Lex, and UnMode welcome the opportunity to provide inputs ahead of the Special Rapporteur's report on "drug policies and responses: a right to health framework on harm reduction". Drawing on previous submissions and other relevant reports[1], this document will provide valuable information to the Special Rapporteur with a specific focus on people deprived of liberty, addressing topics mentioned in questions one, two and five.

Question 1: **The state of harm reduction in prisons and availability, accessibility and quality of services in closed settings[2].**

Penal Reform International (PRI) has reported that the number of people deprived of liberty has reached its highest, with over 11.5 million people incarcerated globally and around a third of the global prison population in pretrial detention, presumed innocent. An estimated 2.2 million people worldwide are detained for drug offences, with 22% (470,000 people) for drug possession for personal use[3] and 50% of the global people population using drugs while incarcerated.[4]

Despite States obligations to protect the right to health of people deprived of liberty, and in disregard of the high risks that closed settings bring for people who use drugs, the Global State of Harm Reduction 2022 (GSHR) reveals that people in prisons are still severely underserved by harm reduction services, showing little expansion since 2020. Only 59 countries globally – with no expansion from 2020 – provide Opioid Agonist Therapies (OAT)[5] in at least one prison. OAT programmes are reported to be operating in prisons in Kosovo, Macau, and Tanzania. However, new data indicates that prisons in Georgia, Hungary and Jordan only offer opioid agonists for detoxification. The scenario is even worse when it comes to the provision of Needle and Syringe Programmes (NSPs), with only 10 countries in the world operating NSPs in at least one prison.[6] There is no NSPs, OAT or naloxone in

[1] For more details on harm reduction and prisons see, Joint Submission to the OHCHR on Prisons and Harm Reduction (2023) Doi https://hri.global/publications/joint-submission-to-the-ohchr-on-prisons-and-harm-reduction/; Joint Submission on Death in Custody to the UN Special Rapporteur on extrajudicial, summary or arbitrary executions (2023). Doi https://hri.global/publications/joint-submission-on-deaths-in-custody/; and Joint Submission on the Sixth Periodic Report on Georgia (2023) Doi https://hri.global/publications/joint-submission-on-the-sixth-periodic-report-on-georgia/

[2] Unless stated otherwise the information provided here refers to the Global State of Harm Reduction 2022. Doi https://hri.global/flagship-research/the-global-state-of-harm-reduction/

[3] For more information, see Penal Reform International and Thailand Institute of Justice, (2023) Global Prison Trend 2023. Doi https://www.penalreform.org/global-prison-trends-2023/

[4]Carpentier. C, Royuela. L, Montari.L and Davis. PH. 2018. The Global Epidemiology of Drug Use in Prisons in *Drug Use in Prisoners. Epidemiology, Implications and Policy Responses.* Edited by Stuart A, Kinner A and Rich J. Oxford University Press. P 18. Doi https://books.google.co.uk/books?hl=en&lr=&id=yAJCDwAAQBAJ&oi=fnd&pg=PA17&dq=prevalence+of+illicit+drug+use+in+prisons&ots=t6Kx8ZbZJn&sig=jrgM8wLIobdLFvK1XleiAtFNtJs#v=onepage&q&f=false; Dolan K, et al. 2015 'People who inject drugs in prison: HIV prevalence, transmission and prevention' International Journal of Drug Policy vol 26:S12-S15.

[5]Albania, Afghanistan, Aotearoa-New Zealand, Armenia, Australia, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Canada, Croatia, Czechia, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, India, Indonesia, Italy, Ireland, Iran, Israel, Kenya, Kosovo, Kyrgyzstan, Latvia, Lithuania, Lebanon, Luxemburg, Macau, Malaysia, Malta Moldova, Mauritius, Montenegro, Morrocco, Netherlands, North Macedonia, Norway, Palestine, Poland, Portugal, Romania, Seychelles, Serbia, Slovenia, Spain, Sweden, Switzerland, United Republic of Tanzania, Tajikistan, Ukraine, United State of America, and United Kingdom and Vietnam.

[6] Canada, France, Germany, Kyrgyzstan, Luxemburg, Moldova, North Macedonia, Spain, Switzerland, Tajikistan, Ukraine. The Global States of Harm Reduction:2023 Update to key data shows that Armenia, which was among the countries that provided NSPs in prisons, has suspended its NSP prison programme.

Latin America and West Central Africa. Canada has the only world's prison-based drug consumption room (DCR).

The fact that some harm reduction services are somehow available does not mean that are accessible in all prisons, or for all prison populations. In Asia, where only five countries provide OAT in prisons,[7] punitive approaches to drugs have translated to poor prison conditions in those countries, which restrict the already limited access to basic harm reduction services.

In Eastern and South Africa, only 5 countries provide OAT in prison. [8] While all countries in that region provide HIV testing and treatment inside prisons, there are many documented barriers to access, particularly for women who use drugs, including humiliating and punitive treatment. Viral hepatitis testing and treatment is largely unavailable in prison in that region.

While OAT is available in most European[9] and Eurasia[10] regions, with 29 countries providing that service in prisons, it is still insufficiently accessible; and in some cases, it is not possible to initiate OAT while incarcerated.[11] In Albania, Latvia, Montenegro and Serbia, people cannot start OAT while in prison, and it is only available if people were on OAT before being incarcerated. NSPs are available in four countries in these regions,[12] but not evenly implemented in all prisons, and there remain barriers that limit access.[13]For example, research in Moldova in 2021 revealed several concerns related to the accessibility of NSPs in prisons, including confidentiality issues and discrimination.

Question 2. Punitive responses and its impact on the overincarceration of marginalised, racialised and vulnerable communities.

Although over 36 countries have removed criminal sanctions for drug possession for personal use, punitive responses to drug policy remain a key contributing factor to prison overcrowding,[14] with drug offences accounting for 22% of the global prison population.[15] Despite the global trend towards abolition of the death penalty, as of 2022, 35 countries still retain the death penalty for drug offences, with 285 people executed which represents and 118% increase from 2021 and an 850% increase from 2020. Additionally, 303 people sentenced to death and more than 3000 currently in death row for drug offences worldwide.[16]

[7] India, Indonesia, Macau, Malaysia, and Vietnam
[8] Eswatini, Kenya, Mauritius, Seychelles, and Tanzania
[9] Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxemburg, Malta, Netherlands, Norway, Portugal, Sweden, Switzerland, and the United Kingdom.
[10] Albania, Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, Czechia, Estonia, Kosovo, Kyrgyzstan, Latvia, Lithuania, Moldova, Montenegro, North Macedonia, Poland, Romania, Serbia, Slovenia, Tajikistan, and Ukraine.
[11] Portugal, OAT is available in 49 prisons, but initiation of OAT is only possible in four, thus OAT is predominantly only available to people who started OAT before going to prison. Italy, despite OAT being available in all prisons, due to bureaucratic barriers it is difficult to enrol in OAT from prison.
[12] Germany, Kyrgyzstan, Luxembourg, Moldova, Spain, Switzerland, Tajikistan, and Ukraine.
[13] One of two prisons in Luxembourg, in one women's prison in Germany (a syringe-dispensing machine), in 15 prisons in Switzerland (covering one fifth of people in prison in the country), and in a decreasing number of facilities in Spain (47 in 2019)
[14] Talking Drugs (2023) https://www.talkingdrugs.org/drug-decriminalisation
[15] Penal Reform International and Thailand Institute of Justice, (2023) Global Prison Trend 2023, page 17. DOI https://www.penalreform.org/global-prison-trends-2023/
[16] For more detailed information, see Girelli, Jofre and Larasati (2022). The Death Penalty for Drug Offences: Global Overview 2022. Doi https://hri.global/flagship-research/death-penalty/

Despite the international law underscoring the States' obligations to protect the rights of all individuals and UN agencies highlighting the need for an evidence-based and human rights approach to drug policies,[17] marginalised groups, including people who use drugs, racial, ethnic minorities, and women, continue to be targeted by law enforcement and negatively impacted by punitive responses to drug policies,[18] resulting in the overrepresentation of these groups among the prison population. UNAIDS estimates that up to 90% of people who inject drugs will be incarcerated at some point in their life.[19] Data confirms the disproportionate impact of pre-trial detention and prison sentences for low-level drug offences on women. Although women make up 6.9% of the prison population worldwide, this group has grown at a faster rate than men, increasing by 60% from 2000 to 2022, as opposed to 20% for the male population in the same period, with 35% of women being imprisoned for drug offences globally.

Punitive responses have disproportionately impacted people of colour and ethnic minorities, almost in all phases of the enforcement of drug laws and policies, from stop and search measures to arrests, prosecutions, or incarceration. The higher rates of searches, arrests, or incarceration for possession of drugs are not justified by a higher prevalence of drug use amongst communities of colour; rather they reflect law enforcement's greater focus and greater use of violence and force in urban areas, lower-income communities, and communities of colour. Evidence shows that contact with the criminal justice system is a critical social determinant of physical and mental health. While most research has been done on the consequences of incarceration, a growing body of evidence shows that this happens in every form of contact with the criminal justice system, and that encounters with the police and arrests have negative impacts on mental health and well-being. Criminalisation acts as a barrier to accessing life-saving harm reduction services, including opioid antagonists such as naloxone that can reverse overdoses. Punitive drug laws and policies are also major drivers of non-consensual medical treatment. Within the criminal justice system, non-consensual drug treatment can take place in the form of compulsory drug detention, mandatory treatment by judicial order, or drug courts and other forms of coerced treatment in which people who use drugs are forced to choose between incarceration and treatment.[20]

[17] UN System Chief Executives Board for Coordination (2018), United Nations System Common Position Supporting the implementation of the International Drug Control Policy through Effective Inter-Agency Collaboration, CEB/2018/2; UN (2021) United Nation System Common position on Incarceration, among others. Daniels et al (2021), Decolonising Drug Policy, *Harm Reduction Journal*, 18:20, DOI https://doi.org/10.1186/s12954-021-00564-7; Harm Reduction International, (2021) The Harms of incarceration, DOI https://hri.global/publications/the-harms-of-incarceration-the-evidence-base-and-human-rights-framework-for-decarceration-and-harm-reduction-in-prisons

[18] Joint Submission to the Committee on the Elimination of Racial Discrimination, (2023) Doi https://hri.global/publications/joint-submission-to-the-un-committee-on-the-elimination-of-racial-discrimination/, Daniels et al (2021), Decolonising Drug Policy, *Harm Reduction Journal*, 18:20, DOI https://doi.org/10.1186/s12954-021-00564-7; Harm Reduction International, (2021) The Harms of incarceration, DOI https://hri.global/publications/the-harms-of-incarceration-the-evidence-base-and-human-rights-framework-for-decarceration-and-harm-reduction-in-prisons

[19] UNAIDS, (2014) The Gap Report 2014. People who inject drugs, DOI: https://www.unaids.org/sites/default/files/media_asset/05_Peoplewhoinjectdrugs.pdfc

[20] Unless stated otherwise, the information provided in this paragraph is taken from Joint Submission to the United Nations Committee on the Elimination of Racial Discrimination on Comments to draft General Recommendation N. 37 on racial discrimination in the enjoyment of the right to health

Question 5. Impacts of incarceration, discrimination, stereotypes, and stigma on people deprived of liberty who use drugs.

Punitive drug policies and limited access to harm reduction services in prisons have a negative impact on the health of people deprived of liberty and deaths in custody. Prisons are high-risk environments for the transmission of diseases due to overcrowding, limited access to clean water and inadequate sanitary conditions, lack of healthcare and access to good-quality food, and mistreatment of people in detention, to name a few.[21] Additionally, the over-representation of vulnerable groups, such as people who use drugs, who are more likely to suffer from poor health, means many people in prison are at higher risk of becoming seriously ill if contracting a disease.[22]

This has been compounded by the COVID-19 pandemic, which exacerbated the structural problems of the prison system and often worsened inhumane living conditions and access to essential health services, including harm reduction.[23] Research by HRI, PRI and others revealed that the COVID-19 pandemic exacerbated the structural problems of the prison system and often worsened inhumane living conditions, with some measures implemented to control the spread of the virus having the effect of restricting the enjoyment of prisoners' rights.[24] Latest HRI's report concluded that measures implemented during the pandemic, such as extended lockdowns and suspensions of visits, seriously impacted the already limited provision of health and harm reduction services,[25] having far-reaching health and human rights implications for people in detention in the countries surveyed.[26] In some cases, these extreme measures continued to be implemented in prisons far beyond when they were lifted in the community, with some health services permanently limited or suspended, raising questions as to their exceptional and temporary nature.[27]

[21] For more detail on prison conditions, see Penal Reform International and Thailand Institute of Justice, 2023. Global Prison Trend 2022. DOI https://www.penalreform.org/global-prison-trends-2022/

[22] Dolan, K., Wirtz, A.L., Moazen, B., et al. 2016, Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees, in The Lancet Series: HIV and related infections in prisoners; European Centre for Disease Prevention and Control and the European Monitoring Centre for Drugs and Drug Addiction. 2017. Systematic review on active case finding of communicable diseases in prison settings. Stockholm: ECDC. Doi 10.2900/348536; Penal Reform International (2007). Health in Prisons: realizing the right to health. Penal Reform Briefing No 2. DOI https://cdn.penalreform.org/wpcontent/uploads/2013/06/rf-02-2007-health-in-prisons-en_01.pdf

[23] For more information, see Sander and Jofré.2022. Prisons After Covid-19: Beyond Emergency Measures. *Harm Reduction International.* Doi https://hri.global/publications/prison-after-covid-19-beyond-emergency-measures/

[24] Sander and Jofré. (2022). Prisons After Covid-19: Beyond Emergency Measures. *Harm Reduction International.* Doi https://hri.global/publications/prison-after-covid-19-beyond-emergency-measures/; Penal Reform International (2021) Global Prison Trends 2021 Doi https://www.penalreform.org/global-prison-trends-2021/; and Penal Reform International (2022) Global Prison Trends 2022. Doi https://www.penalreform.org/global-prison-trends-2022/

[25] For example, Lockdowns were reportedly implemented in prisons at the beginning of the pandemic and at various other times in all countries surveyed, with most people confined in their cells for sometimes 23 or 24 hours a day, and with full suspension of regular activities, including work, school, leisure and physical activities. Suspension of visits was also reported in all countries studied, which prevented not only family and friends from coming into prisons, but external services as well, including harm reduction and other health service providers.

[26] Benin, Burkina Faso, Canada, France, Ghana, Indonesia, Italy, Mexico, Kenya, Kyrgyzstan, Mauritius, Moldova, Nepal, Switzerland, and the United Kingdom.

[27] That is the case in the UK, where people were found to be locked up in their cells for up to 23 hours a day in February 2022 after restrictions were lifted in the community. In Mexico, for example, medicine shortage continued to be a problem, and the quality of services reportedly remained subpar. In at least four prisons in Mexico, the number of visits has been permanently reduced, limiting the access to health and sanitary products that people in detention can only have access to through their families.

Evidence shows that sharing injecting equipment – a common practice in prison – has been linked to outbreaks of HIV in prisons in Iran, Lithuania, Thailand, the United Kingdom and Ukraine.[28] Globally, the prison population is 7.2 times more likely to be living with HIV that the general community, with 3.2% of prisoners living with HIV, and 15.1% living with hepatitis C.[29] People in prison are also disproportionately vulnerable to overdose, both during their sentence and immediately after their release. Male and female prisoners are 19 and 69 times, respectively, more likely to die from an overdose than the non-prison population.[30]

Finally, according to the joint submission by HRI, Prom-Lex and EPLN, accidental or intentional intoxication is a recurring cause of death in custody. EMCDDA's report concludes that suicide is the leading cause of death among incarcerated people in Europe, with a considerable proportion of cases linked to drug-related problems. In Ireland and Scotland, drug overdose is a main contributor to deaths in prisons. In the USA overdose is identified as the third leading cause of death in jails. Similarly, However, due to the lack of official, updated, disaggregated information on deaths in custody for drug use, transparency issues and inadequate death examination policies and practices, it can be difficult to aptly classify intoxication-related deaths as overdoses (accidental) or suicide (intentional) and cases may be under investigated and family's victims without due remedies.[31] Research by PRI and partners has found that in many countries, data on drug-related deaths in prison is not available (and often not in the community either), with at least 40 countries around the world publishing little or no data[32] globally investigations of deaths in prison remain inadequate and, where investigations do take place, they rarely lead to accountability and reform. In many countries such as Mexico, Japan, France, Portugal, and Turkey, full investigations are usually only triggered in cases of 'suspicious' or violent deaths, which rarely result in redress for victims and often exclude any preventive approach.[33]

Conclusions and recommendations

Specific obligations for protecting the health of people deprived of their liberty derive from their inherent dignity and value as human beings, as well as their rights to life, to health and to be free from torture and ill-treatment.[34] The increased degree of vulnerability caused by incarceration puts a

[28] Dolan K, et al (2015) 'People who inject drugs in prison: HIV prevalence, transmission and prevention' (2015) International Journal of Drug Policy vol 26:S12-S15.

[29] Dolan K, Wirtz AL, Moazen B, Ndeffo-mbah M, Galvani A, Kinner SA, et al. (2016) Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. The Lancet 388(10049) 1089–102; UNAIDS (2021) HIV and people in prisons and other closed settings. Human Rights Fact Sheet Series DOI https://www.unaids.org/sites/default/files/media_asset/06-hiv-human-rights-factsheet-prisons_en.pdf

[30] Binswanger IA, Nowels C, Corsi KF, Glanz J, Long J, Booth RE, et al. (2012) Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors. Addict Sci Clin Pract 7(1):3.

[31] According to the joint submission, as part of the research of the Global State of Harm Reduction, HRI disseminated a survey to community and civil society organisations and experts around the world in 2022, which included one question on the availability of data on drug-related deaths in prisons. Based on the findings of that survey, it was concluded that "data on drug-related deaths in prison is not available (and often not in the community either), with at least 40 countries around the world publishing little or no data." Similarly, a 2023 WHO reveals that out of 53 European countries, only 35 could provide data on causes of death in prison

[32] Penal Reform International, *Deaths in prison: Examining causes, responses, and prevention*, December 2022, p.9, https://www.penalreform.org/resource/deaths-in-prison-examining-causes-responses-and-prevention/

[33] Penal Reform International and University of Nottingham, *Investigating deaths in prison: A guide to a human rights-based approach*, September 2023, p.5.

[34] Art. 1 and 2 of the Universal Declaration of Human Rights; Art 6 of the International Covenant on Civil and Political Rights; Art, 12 of the International Covenant on Economic, Social and Cultural Rights; UN General Assembly (1990), Basic Principles for the Treatment of Prisoners, UNODC, et al. (2006), Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response; UNAIDS (1997), Prisons and AIDS; WHO (1993), Guidelines on HIV infection and AIDS in prisons; Istanbul Protocol (2022), UN Committee Against Torture (2014), Observations of the

heightened duty of care on the part of the State to protect their lives, and their physical and mental health.

Additionally, following the principle of equivalence of care,[35] international obligations bind States to provide at least the same standard that is available in the broader community including the provision of adequate health services that are closely linked to the general health service, continuity of care as people move between prisons and the broader community, including for infectious diseases and drug dependence provision of essential medicines, including methadone and buprenorphine and underlying determinants of health such as fresh air, clean water and adequate sanitation, non-discrimination, and active and informed participation in decisions affecting their health.[36]

In line with these international standards, and with the information provided through this submission we encourage the Special Rapporteur to recommend Member States to:

a. Decriminalise drug use and apply health and human rights centred community-based responses to drug use to reduce prison populations and promote the right to health;
b. Introduce decongestion and early release measures to reduce prison overcrowding;
c. Ensure drug-related offences are not subject to any blanket restrictions in decongestion and early release mechanisms;
d. Recognise harm reduction as an essential element of the right to health and incorporate it into prison health programmes and policies;
e. Ensure that good quality harm reduction services are available, accessible on a voluntary basis for all people in detention;
f. Ensure that people can continue accessing harm reduction services upon release without discrimination; and
g. Ensure the same standards of health care that are available in the community and provide access to necessary health-care services to prisoners free of charge without discrimination.

Commission against Torture on the revision of the Standard Minimum Rules for the Treatment of Prisoners, UN Doc. CAT/C/51/4; among others

[35] UN General Assembly (1990), Basic Principles for the Treatment of Prisoners, Principle 9; UN General Assembly (8 January 2016), Revised UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), Rule 24(1); UNODC et al (2006), Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response; UN General Assembly (1982), Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment, UN Doc A/RES/37/194, Principle 1; Council of Europe, Committee of Ministers (1998), Recommendation No. R (98) 7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison, p. 40. UN (2021) United Nations System Common position on Incarceration; UN System Chief Executives Board for Coordination (2018), United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration, CEB/2018/2

[36] HRI, Prisons After Covid-19: Beyond Emergency Measures, available at: https://hri.global/publications/prison-after-covid-19-beyond-emergency-measures/;


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