THEMATIC CHAPTER: PRISONS

AUTHOR OF PRISONS CHAPTER: Tríona Lenihan

Tríona Lenihan is a human rights advocate with 12 years of experience, mostly in the justice sector. She holds a BCL (Law) and LLM in International Human Rights Law and Public Policy from University College Cork. Based in London, she previously led Penal Reform International's policy and international advocacy programme, where she supported implementation of human rights standards in prisons. She is currently an international policy adviser on rule of law and human rights at the Law Society of England and Wales.

PRISONS

The term ‘prisons’ is used to describe places of criminal legal detention, where individuals are held either pre-trial or under sentence. It does not include other places of deprivation of liberty where harm reduction services are also needed, including immigration or police detention or mental health institutions.

PLACES OF HIGH NEED AND OPPORTUNITIES FOR HARM REDUCTION

An estimated 11.5 million people were in prison globally in 2022.[1] While at least 66 jurisdictions in 40 countries have in some way decriminalised personal use and possession of drugs,[2] punitive drug policies remain a key driver of imprisonment worldwide.[3]

In 2022, 51% of global prosecutions (1.4 million people) and 54% of convictions (900,000 people) for drug-related offences were for drug use or possession.[4] Punitive drug policies have also led to the overrepresentation of racialised and marginalised groups in the criminal legal system.[5] Over one in three women in prison globally are incarcerated for drug offences, rising to 60-80% in some Latin American and Asian countries.[6]

The criminalisation of drug use means people who use drugs are over-represented in prisons: an estimated one third to half of all people entering prison have a history of drug use.[7] The likelihood of injecting drug use decreases with incarceration, however, some people continue or start injecting drugs while in prison.[8] This is linked to poor prison environments that lack purposeful activity and where drug use is acceptable or even pressurised by peers.[9] High-risk behaviours, such as sharing syringes, also increase in prisons. In Australia, for example, data from 2022 shows 73% of people entering prison had used drugs in the past year.[10] On release, 37% had used illicit drugs in prison; 14% injected drugs in prison and 13% shared injecting equipment.[11]

The situation is compounded by the fact that people in prison are likely to have a poorer health status

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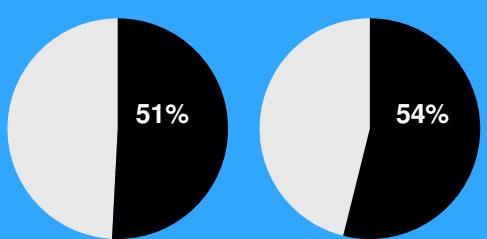
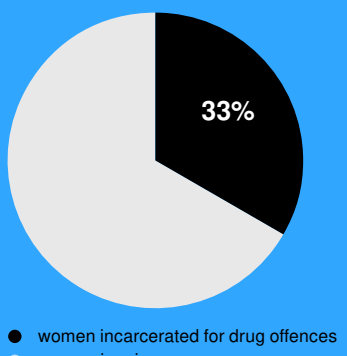


1/3rd of all women in prison globally are incarcerated for drug offences



than the general population[12] and unfavourable environmental factors in prison, such as overcrowding and inadequate access to healthcare and harm reduction services. As a result, people in prison have an alarmingly high risk of contracting infectious diseases and experiencing other negative health outcomes compared to the general population. The latest figures from UNAIDS show

the global median of HIV prevalence reported among people in prison in 2023 was almost double that of the general population.[13]

HIV prevalence in prisons is highest in Eastern and Southern Africa (12% regionally), and was estimated to be as high as 21% in Zambia and 35% in Zimbabwe in 2022.[14] Over 15% of people in prisons globally are living with hepatitis C virus (HCV) and 5% have chronic hepatitis B virus.[15] In the USA, HCV is nearly nine times more prevalent in prisons than in the community.[16]

The increased risk of negative health outcomes from infectious diseases and unsafe drug use in prisons means that harm reduction interventions are critically needed and can have a significant, positive impact.[17] For some, prisons may provide an opportunity for improved adherence to treatment and increased use of harm reduction services. The UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) require that, when people enter prison, they are assessed for symptoms or risk of drug withdrawal and any treatment that is needed is provided (Rule 30c). Failure to provide such treatment may amount to ill-treatment and is thus prohibited under the Convention Against Torture.[18]

As closed settings, prisons provide an opportunity for universal screening and 'micro-elimination' of communicable diseases among a high-risk population.

For example, in France, where HCV is 10 times more prevalent in prisons than outside, one remand prison has succeeded in eliminating the virus for the past seven years, attributed to a proactive screening policy. The prison, which has also set up a syringe exchange programme and an exchange for stimulant smoking kits, has had no overdose deaths for 10 years.[19a] In Virginia, USA, where HCV prevalence is 10 times higher among people in prison than the general population, a pharmacist-led telemedicine HCV clinic achieved a 97% cure rate among 1,040 people in prison with chronic HCV who were treated between 2020 and 2022.[20]

AVAILABILITY OF HARM REDUCTION IN PRISONS

International human rights norms and standards, including the Nelson Mandela Rules, state that people in prison are entitled to the same standard of healthcare as people in the community (the principle of equivalence).[21] This is interpreted to apply to harm reduction services, meaning that services in prison should be as available and accessible, and of the same quality and voluntary nature, as those that exist for the general population. Moreover, experts have questioned whether the aim, instead of equivalence of care, should be equivalence of objectives and results, which would involve a higher standard of care for people in prison.[b]

The United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO)

a This is an unsanctioned NSP operating without formal approval from the government.
b This opinion is supported by the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment, and the former UN Special Rapporteur on the right to health. See Harm Reduction International, (2016), *HIV, HCV, TB and Harm Reduction*, HRI, London.

include needle and syringe programmes (NSP), opioid agonist therapy (OAT), naloxone distribution and other services in their latest recommended interventions for people in prisons.[22] UN human rights bodies have called for harm reduction to protect the right to health in prisons,[23] and 108 countries recognise harm reduction in their national laws or policies.[24] Yet, implementation in prisons remains far behind implementation in the community and wholly inadequate, with little improvement since the last *Global State of Harm Reduction* report.

OPIOID AGONIST THERAPY

OAT is available in at least one prison in 60 countries (compared to 93 in the community). This is only one more country than in 2022 when 59 countries offered OAT in prison. OAT is now known to be available in at least one prison in Algeria, Puerto Rico and Türkiye, but we can no longer confirm availability in Bulgaria and Palestine.

Availability of OAT in prisons varies widely between regions. Most countries that provide at least one prison-based OAT programme are in Western Europe (21 countries) and Eurasia (19 countries). In contrast, fewer countries offer OAT in prisons in the Middle East and North Africa (six countries)[c], Asia (five countries)[d], Eastern and Southern Africa (four countries)[e] or Oceania (two countries)[f]. Puerto Rico offers the only prison-based OAT programme in Latin America and the Caribbean, and there are no known OAT in prisons in West and Central Africa.

In countries where OAT is available in at least one prison, coverage across the prison estate varies significantly. OAT is available in all prisons in Austria, Kosovo and France.[25] In Romania, OAT is functional in 15 prison units out of 45.[26,27] Similarly, in Mauritius there are four methadone dispensing sites among 11 prison facilities,[28] including one at the women's prison.[29] Outpatient OAT clinics were initiated in prisons in Punjab in India in 2022 (in 9 out of 24 prisons). However, there have been reports of staffing issues and a lack of testing kits,[30] and nationwide data on people who inject drugs in prisons and coverage of OAT is largely unavailable.[31]

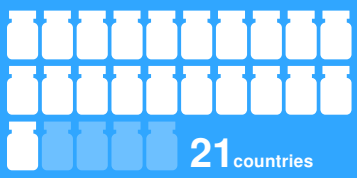
NEEDLE AND SYRINGE PROGRAMMES

An NSP is available in at least one prison in 11 countries (compared to 93 in the community). This is two more than in 2022 when nine countries provided NSP in prison. France[g], Iran, North Macedonia and Ukraine now provide at least an NSP in at least one prison, but prison-based NSP is no longer available in Armenia.[32] Apart from Canada[33] and Iran,[34] all identified NSPs in prisons are in Eurasia (Kyrgyzstan,[35] Moldova, North Macedonia, Tajikistan, Ukraine[36]) and Western Europe (Spain,[37] Luxembourg,[38] Germany,[39] Switzerland,[40] France[41g]). Ukraine's first prison NSP opened in Odesa prison in 2023, in collaboration with the NGO FREE ZONE. Based on a prison survey that revealed 50% of respondents had used drugs and 40% were interested in participating in an NSP,[42] a comprehensive service package was developed. This included training for people in prison and prison staff, and technical support for peer consultants who FREE ZONE later employed. By July 2024, 592 people had received around 19,500 services from the NSP, and 13 people in prison became peer workers to support social reintegration once people were released. Following the success of this model, another prison facility in Ukraine has recently proposed a similar programme.[43] In contrast, the

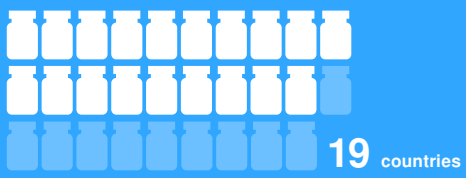
c Afghanistan, Algeria, Iran, Israel, Lebanon and Morocco.
d India, Indonesia, Macau, Malaysia and Vietnam.
e Kenya, Mauritius, Seychelles and Tanzania.
f Aotearoa New Zealand and Australia.
g This is an unsanctioned NSP operating without formal approval from the government.

AVAILABILITY OF OPIOID AGONIST THERAPY IN PRISONS BY REGIONS

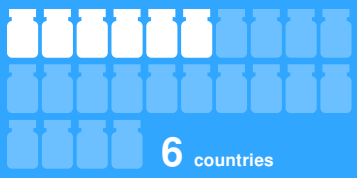
WESTERN EUROPE



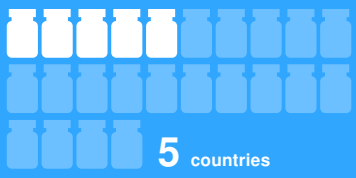
EURASIA



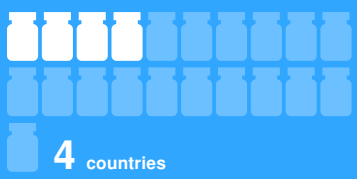
MIDDLE EAST AND NORTH AFRICA



ASIA



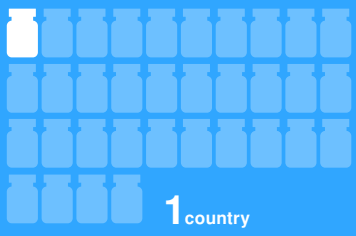
EASTERN AND SOUTHERN AFRICA



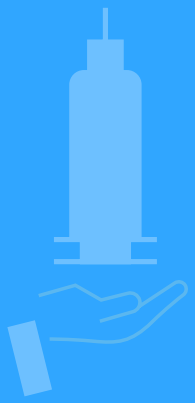
NORTH AMERICA

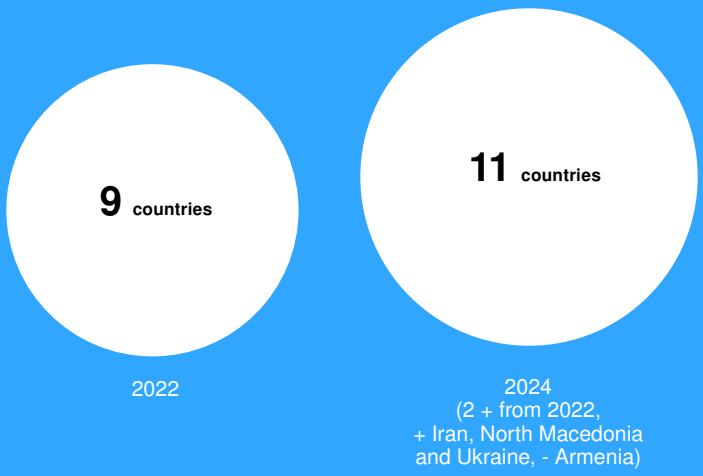
OCEANIA

LATIN AMERICA AND THE CARIBBEAN



NUMBER OF COUNTRIES WITH NEEDLE AND SYRINGE PROGRAMMES (NSP) IN PRISON

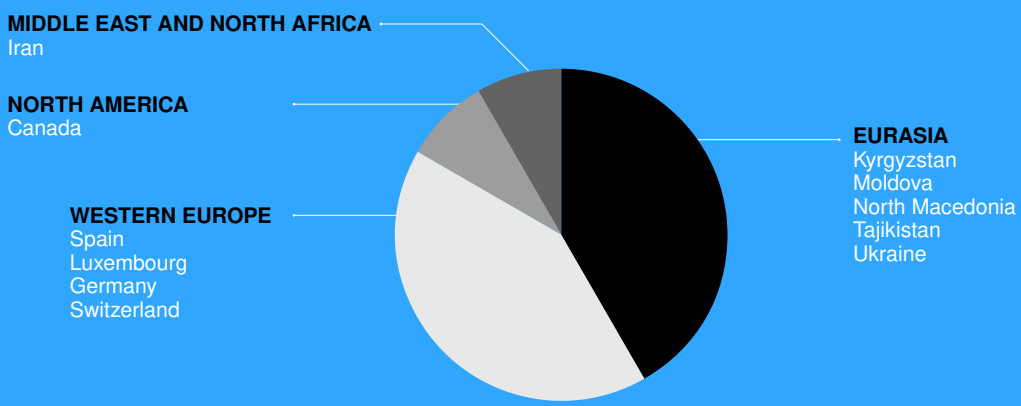




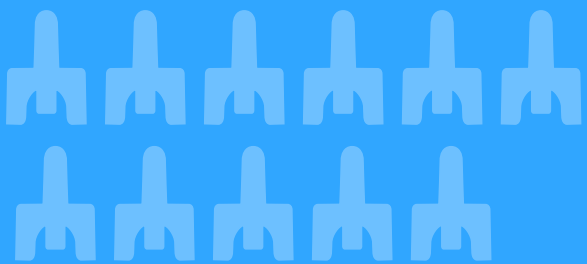
2022

2024
(2 + from 2022,
+ Iran, North Macedonia
and Ukraine, - Armenia)

AN NSP IS AVAILABLE IN AT LEAST ONE PRISON IN 11 COUNTRIES IN 2024



TAKE-HOME NALOXONE AVAILABLE ON RELEASE IN AT LEAST ONE PRISON



AVALIABLE IN 11 COUNTRIES

France
Germany
Italy
Ireland
Norway
Estonia
Lithuania
Ukraine
Canada
USA
Australia

Austrian government has said it does not envisage implementing NSP in prisons, stating that the country's prisons' substitution programme offers numerous ways to stabilise substance use in line with external OAT guidelines.[44]

NALOXONE

Take-home naloxone is available on release in at least one prison in 11 countries, mostly in Europe (France,[45] Germany,[46] Italy,[47] Ireland,[48] Norway,[49] Estonia,[50] Lithuania,[51] Ukraine[52]) and North America (Canada[53] and the USA[54]), plus one scheme in Oceania (Australia[55]). However, the level of coverage varies significantly. Naloxone-on-release is only available in 3 out of 190 prisons in Italy, for example.[56] It is available in most prisons in British Columbia, Canada[57] and Victoria, Australia,[58] but in both countries it varies by state. In some places, such as France, it requires a prescription,[59] and in others it is delivered through civil society partnerships. In Ireland, for example, the Irish Red Cross provides peer-to-peer programmes on overdose prevention and naloxone training to equip people with knowledge of and access to naloxone on release from prison.[60]

Within prisons, naloxone tends to only be administered by staff. This limits its effectiveness, since staff will not always be immediately available in overdose situations, and the time they take to respond could be the difference between life and death.

In the Australian Capital Territory, following discussions with labour unions and training for staff, naloxone has been included in prison officers' first aid kits.[61] In Ireland, it can only be administered in an emergency by a nurse, and in Canada, it is only accessible to prison healthcare or security staff; people in prison cannot have naloxone kits in their cells in case their cellmate experiences an overdose.[62] Evidence relating to this staff-only approach points to its failings. For example, the U.S. Department of Justice Office of the Inspector General (OIG) found that, despite at least 70 people dying from a drug overdose in federal prisons between 2014 to 2021, staff were hesitant to administer naloxone in a timely manner; medical staff told the OIG that guards trained to use naloxone were "uncomfortable" doing so.[63]

DRUG CONSUMPTION ROOMS

Canada opened its first prison-based overdose prevention site (OPS), referred to elsewhere as a drug consumption room (DCR), in Drumheller Institution in Alberta in 2019. Here, people in prison can access sterile syringes, consume drugs in private rooms, and medical staff (not correctional officers) are on hand in case of overdose. Following criticism for delays, two more OPSs opened in 2023 at the Springhill Institution in Nova Scotia and Collins Bay Institution in Ontario. The Drumheller OPS received its first visit from a client after three weeks of opening, but it has now logged nearly 2,000 visits. The first visit from a client to the Springhill OPS took three months.[64] The experience in Canada shows there is a period after an OPS opens when awareness must be raised and trust must be built among people in the prison so they feel confident to use the service. In federal prisons in Canada, 46 people died from suspected drug overdoses and another 728 people nonfatally overdosed between 2011 to 2022.[65] To date, there have been no overdose deaths at any facility with an OPS since the service has been active.[66]

BARRIERS TO ACCESS

Making a harm reduction service available in a prison does not necessarily make it fully accessible. In some countries, OAT in prisons is

limited to people who were prescribed OAT before incarceration. This is the case in some Eurasian countries, including Albania, Bulgaria, Latvia, Montenegro and Serbia.[67] Similar restrictions apply in Lebanon,[68] Macao (China)[69] and Mauritius.[70] Even when OAT is available to everyone, regardless of whether someone has been on OAT before prison, there can be increased barriers for those who start OAT while incarcerated, such as treatment waitlists and extensive wait times of up to multiple months, leading to withdrawal and other negative health outcomes.[71] In Victoria, Australia some people have reported commencing OAT post-release to ensure continuity of care if reincarcerated.[72]

Among the countries surveyed for this report,

the most reported barrier that prevents people in prison from accessing harm reduction, apart from a lack of services, is people's fear of punishment for drug use or possession (in 7 of the 10 countries that provided information)[h], followed by the fear of losing other rights or privileges, privacy concerns, restrictive eligibility criteria and stigmatisation or ill-treatment by staff or peers.

RISK OR PERCEIVED RISK OF SANCTIONS OR LOSS OF RIGHTS OR PRIVILEGES

In Romania, once someone enters a drug treatment programme, they are reportedly declared unfit to work while in prison, which means they will lose their income and cannot participate in a meaningful activity.[73] The HIV organisation Asociația Română Anti-SIDA has found the lack of demand for NSP is linked to the fact that people who request syringes are not given a guarantee that they will not face sanctions.[74] In Indonesia, research has found people participating in OAT programmes in prison were perceived by both prison staff and peers to be engaged in illicit drug use. They were heavily stigmatised; they were seen as lazy, poor, dirty and unproductive people and were presumed to have HIV.[75] This multi-layered, intersectional stigma affected not only the OAT clients' quality of life and mental health but also their access to parole, and therefore the possibility of early release. Similarly, in England and Scotland, service users have reported that while people who disclose use of heroin on admission to prison are offered help, those who disclose later are met primarily with a punitive response and are often suspected of selling drugs or other activities which violate prison rules. This leads people in prison to fear that disclosing opioid use will damage their prospects of accessing home detention, curfew, release on temporary licence or parole.

In Canada, only 20% of people approved for an NSP were utilising the service (as of June 2022).[76] Canada's Correctional Investigator has attributed this poor uptake to various factors, including the prison service's zero-tolerance drug strategy, which conflicts with harm reduction principles, and active opposition to harm reduction among frontline prison staff.[77] Similarly, a study in Western Canada found women in prison perceived NSP as being incompatible with a prison system that continues to criminalise drugs.[78]

LACK OF CONFIDENTIALITY AND ANONYMITY

In Moldova, uptake of OAT is believed to be limited by confidentiality breaches as well as stigma and a prison subculture that informally regulates access. Those who accept methadone treatment are frequently subject to bullying and isolation, directed by leaders among the prison population.[79] Despite

h Romania, Ukraine, Morocco, Moldova, Australia, Canada and Spain.

an NSP being available in most Moldovan prisons (34 sites, across 15 out of 17 prisons), a survey in 2020 found 22% of people who inject drugs in prison shared injecting equipment, suggesting the lack of anonymity in accessing the service due to the conduct of peers and medical staff may be a deterrent.[80] Perceived negative consequences of disclosing drug dependence reported by people in prison in England and Scotland include being looked down on by prison staff and peers, being considered weak and a target for bullying by other people in prison and increased attention from prison security, including more frequent body and cell searches.[81]

SPECIFIC BARRIERS FOR WOMEN IN PRISON

Women who go to prison often have complex circumstances. Many have histories of trauma, and they have higher levels of mental health issues and needs, including drug dependence, than men. All these issues are exacerbated in prison.[82] The UN Rules on the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) require specialised treatment programmes in prisons that are designed for women with substance dependence, 'taking into account prior victimization, the special needs of pregnant women and women with children, as well as their diverse cultural backgrounds' (Rule 15).[83] The Bangkok Rules also state that women in prison should receive medical screening on entry and healthcare while incarcerated, including mental healthcare, HIV treatment, care and support, support in relation to suicide and self-harm and preventive healthcare services which are responsive to the specific needs of women.

Yet, harm reduction is particularly limited for women in prison. The prison-based harm reduction services that exist are concentrated in men's facilities.

For example, the only therapeutic community in Moldovan prisons is in a male facility.[84] The two prisons in Ireland that have consultant-led, 'in-reach' drug dependence services only accommodate men.[85] The impact of such a gap in services can be fatal. For example, successive coronial inquests in Australia have identified service provision issues in women's prisons as contributing factors in women's deaths.[86]

Where harm reduction services are available in prisons, they are rarely tailored to women's specific needs and, as in the community, women who use drugs face particular stigma and discrimination when accessing services in many countries.[87]

In Eastern and Southern Africa, civil society has documented widespread barriers to accessing HIV testing and treatment in prison for women who use drugs, including humiliating and punitive treatment by prison staff and services only being available in a limited number of facilities.[88]

In Georgia, OAT (for detoxification) is not available in the women's prison. Instead, women in need of OAT are temporarily transferred to a treatment facility in a male prison where they share a psychiatric ward with men.[89] As a result, uptake is low among women who accounted for only 2 of the 754 people that benefited from prison-based OAT in 2021.[90] Discriminatory attitudes from staff and feelings of shame that lead some women to hide their drug use or dependency means it is likely that many women in prison do not access the services available in the system and deal with withdrawal on their own.[91]

Researchers have noted the dearth of research on OAT for women in Southeast Asian prisons. This fuels the continued invisibility of women in prison and possible systemic failures to safeguard and uphold their rights, in violation of the Bangkok Rules.[92]

OTHER MARGINALISED PEOPLE IN PRISON

Other groups that face particular barriers accessing harm reduction in prisons are foreign nationals (partly linked to language barriers, which have been reported in Armenia[93] and Ireland[94]), LGBTQI+ people, children, Black, Brown, ethnic minority and Indigenous people and people engaged in sex work (reported in Indonesia[95] and Armenia[96]).

The challenges these marginalised populations face in prisons are often similar to the issues they experience in the community, including services that are not responsive to their needs. In Morocco and Armenia, for example, standard services are generally provided to all individuals without consideration of the specific needs of women, LGBTQI+ people or other groups.[97] The lack of tailored services can have significant consequences for people's health and life. Research has exposed a much higher rate of opioid overdose deaths among Black people in prison in Ontario, Canada. The risk is even higher for Black women due to multiple layers of marginalisation based on race, gender and incarceration. The researchers found an urgent need for interventions to address factors including sexism and systemic and structural racism, and for culturally appropriate harm reduction and treatment services in custody and post-release. These services should be comprehensive, multisectoral, community-based and developed in partnership with Black communities.[98]

Sex workers who use drugs face barriers accessing services due to the layered stigma surrounding drug use, sex work and sexual orientation, which in many countries are all criminalised to varying degrees. In Indonesia, trans and gender diverse sex workers who use drugs who are incarcerated are failed by existing harm reduction structures. In Bali, this has led the Women and Harm Reduction International Network (WHRIN) and YAKEBA to launch Project GAP to identify and address data, service provision and stakeholder accountability gaps for sex workers who use drugs.[99] As part of the project, focal points for sex workers who use drugs have been trained on harm reduction, and harm reduction providers have been trained on sexual orientation and gender identity rights, sex worker rights and gender responsive services.

In some countries, trans and gender diverse people in prison are held in long periods of lock-up and solitary confinement, often on grounds of protection. This limits their access to all services in prison, including harm reduction. This has been reported in Ireland,[100] Zambia and the USA.[101]

“ The challenges these marginalised populations face in prisons are often similar to the issues they experience in the community, including services that are not responsive to their needs. The lack of tailored services can have significant consequences for people’s health and life.”

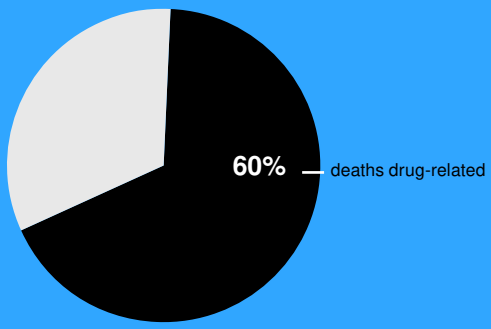
CONTINUITY OF CARE ON RELEASE FROM PRISON

The period following release from prison is one of heightened vulnerability as people experience multiple challenges re-entering society and face higher risks of relapsing to substance use as well as overdose and death.[102] In England and Wales, over 60% of deaths among people in the first two weeks after prison release since 2021 have been drug-related.[103] The risk of dying from an opioid overdose among men and women who had been in prison in Ontario, Canada between 2015 and 2022 was 28 times and 78 times higher, respectively, than in the general population.[104] The risk of injecting-related infections is higher in the first two weeks after release in Australia, with factors such as poor access to health and harm reduction services, poverty, experience of homelessness and reduced opioid tolerance after incarceration likely to be contributing factors.[105]

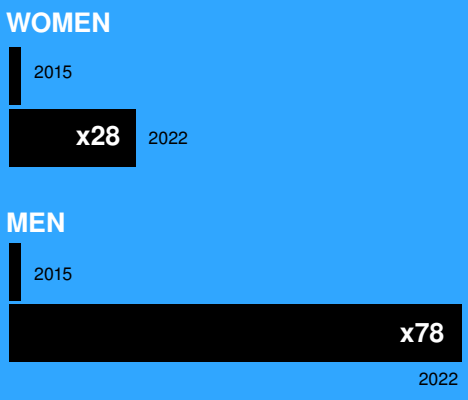
Receiving OAT while in prison is crucial for reducing deaths among people who use drugs for six months after release (both all-cause deaths and overdose deaths).[106]

Post-release OAT retention is associated with lower rates of contact with emergency healthcare after release [107] and higher rates of contact with broader primary healthcare.[108] Higher doses of methadone (at least 80 mg per day) before release have been shown to increase the likelihood of retention in post-release OAT. In Malaysia, for example, 46% of people in prison who received a higher methadone dose stayed on OAT after release compared to 28% of those on lower doses.[109] A review of three Southeast Asian countries found family support and reducing societal stigma were key enablers to staying on OAT post-release, while barriers to retention included a lack of trained prison staff and high turnover, poor coordination between prison and community and limited availability of treatment.[110] The researchers noted that, despite the growing

In England and Wales, over 60% of deaths among people in the first two weeks after prison release since 2021 have been drug-related.



The risk of dying from an opioid overdose among men and women who had been in prison in Ontario, Canada between 2015 and 2022 was 28 times and 78 times higher than the general population.



availability of OAT in the community in the region, the challenge remains to support continuity of care both in and out of prison.

In most of the countries surveyed for this report,[i] some form of support is available to people accessing harm reduction in prisons so they can continue accessing services after release and is often provided by civil society organisations (CSOs). However, significant challenges remain. In Victoria, Australia, for example, if people have a significant mental health disorder or are on HCV treatment there are policies for active referral to community-based treatment, but most other healthcare continuity is simply a paper-based health discharge summary provided to people on release to take to their healthcare providers.[111]

In a positive move, Community Transition Teams have been expanded in British Columbia, Canada, from covering 5 correctional centres in the pilot launched in 2019 to province-wide coverage (10 centres), with support extended from 30 to 90 days following release.[112] This initiative of BC Mental Health and Substance Use Services (part of the Provincial Health Services Authority) aims to reduce overdose deaths, enhance health outcomes and reduce the harms associated with repeat involvement with the criminal legal system.[113] The teams are made up of social workers, peer support workers, Indigenous patient navigators and nurse prescribers who provide short-term clinical intervention and link clients to mental health and substance use services in the community.[114]

MANAGEMENT OF HARM REDUCTION IN PRISONS

Prison healthcare should be organised in close relationship with the national health system in a way that ensures continuity of treatment and care, including for HIV, tuberculosis, other infectious diseases and drug dependence, as required by the Nelson Mandela Rules.[115] Both the WHO and the UNODC recommend that the most effective way of doing this is to assign responsibility for prison healthcare to the national health authority, rather than the prison administration.[116] In Germany, for example, prison healthcare is under the ministries of justice in the 16 *Länder* (states), and care for people with opioid dependency is fragmented; some Länder have almost no waiting list for prison-based OAT and others provide hardly any treatment at all, meaning people on OAT will not be able to continue in prison.[117] In Armenia, while the Penitentiary Medical Centre collaborates with healthcare institutions that provide harm reduction, significant issues in continuity of care mean people face interruptions in the services they have initiated both upon entering and leaving prison.[118] The failure to transfer responsibility for prison health to the regional health services in Spain is seen as a barrier to the expansion of harm reduction in prisons.[119] Countries that have transferred responsibility for prison health to the health ministry include Norway, Finland, Italy, England and Wales and Kazakhstan.[120] In April 2024, Portugal proposed a gradual transfer, with the aim of ensuring people have uninterrupted access to healthcare during incarceration and upon release by 2030.[121]

DELIVERY OF HARM REDUCTION IN PRISONS

In almost all the countries surveyed, harm reduction in prisons is delivered by a range of providers. In Ukraine, for example, healthcare staff with specialised training manage testing, treatment and the coordination of OAT, while counselling, information and educational activities are conducted by social workers or peer volunteers from the prison, and non-governmental organisations are involved with NSP.[122] Services are most commonly delivered by healthcare staff that are trained for this purpose

i Respondents of the prisons thematic survey in 11 out of 14 countries indicated that some form of support is available to people accessing harm reduction in prisons to continue access upon release.

(in 10 of the 11 countries where information was available)[j] and outside organisations like CSOs (9 countries).[k] Prison staff deliver some harm reduction in more than half of the countries,[l] often but not always with dedicated training.

Peer programmes exist in 7 out of the 11 countries.[m] In Morocco and Ireland, these focus on training peer educators in prisons. The Irish Red Cross (IRC) provides peer programmes on overdose prevention and naloxone training to prepare people for release (in prison, naloxone may only be administered by a nurse in an emergency). IRC peers also run HCV and HIV awareness and anti-stigma campaigns, with voluntary screening.[123]

QUALITY OF SERVICES IN PRISONS

The quality of information and services provided is often lower in prisons than in the community, resulting in poorer experiences and outcomes for clients. A recent study found 80% of people receiving OAT in Estonian prisons reported not receiving the guidelines or rules at the beginning (compared to 20% in the community), and no one had attended peer-led support groups, suggesting these services are likely not offered in prisons.[124] About half said there was no designated person within the prison for the services, implying inadequate oversight and support for people undergoing OAT in prisons.[125]

Research has also shown about half of people receiving OAT in prisons in England were pleased with the service they received, while the other half were disappointed, suggesting that good practice is reliant on the culture and commitment of healthcare and prison staff in individual establishments.[126]

Participants emphasised that, in almost every case, a peer or staff member treating them with compassion, as a human being, was key to their engagement and commitment to treatment or recovery.

SCALE UP AND SUSTAINABILITY OF SERVICES IN PRISONS

Most harm reduction programmes in prisons, including OAT and NSP, are small with limited coverage and unevenly distributed across prison systems, with many relying heavily on donor funding and support.[127] National scale up and linkage to national HIV and public health programmes is crucial to ensure equity across prisons and between prisons and the community, while incorporation into state budgets ensures sustainability by protecting services from fluctuations in external funding. In Romania, for example, NSP, OAT and prevention programmes for groups at increased risk of HIV were dramatically reduced once funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) ended, and the government was not able to take over and sustain the financing of services.[128]

In contrast, some prisons in Moldova started offering harm reduction services in 2000 through international funding and technical assistance. Over the years, the country developed a supportive regulatory environment and started funding services from the state budget[129] and has also expanded services.[130] Harm reduction programmes in prisons in Mauritius are funded by the government, mainly through the ministry of health and other ministries' budgets, with contribution from the Global Fund for specific items.[131]

j Pakistan, Mauritius, Romania, Ukraine, Moldova, Morocco, Australia, Canada, Ireland and Spain.
k Pakistan, Romania, Ukraine, Moldova, Morocco, Australia, Canada, Ireland and Spain.
l Mauritius, Romania, Ukraine, Morocco, Australia, Canada and Spain.
m Mauritius, Ukraine, Moldova, Morocco, Australia, Canada and Ireland.

Among the countries surveyed for this report, the biggest barriers to the introduction or expansion of harm reduction in prisons were laws prohibiting drug consumption and sexual relations in prisons, stakeholder support for the ideological principles of abstinence and drug-free prisons, and a lack of support from staff and the general population. In Australia, unions for prison staff are strongly against prison-based NSP and wield considerable power over aspects of prison policies which they believe (despite a lack of evidence) could compromise their health.

In a workshop held by the International Network on Health and Hepatitis in Substance Users – Prisons Network in October 2023, critical barriers preventing the scale up of prison-based hepatitis services were identified as the lack of political will, poor knowledge, attitudes and awareness among prison leadership and staff of viral hepatitis and harm reduction, a lack of education and information on safe injecting practices, stigma around people who use drugs in prison, a lack of sustainable financing and shortages of medical staff.[132]

Importantly, researchers have noted that while every effort should be made to expand and improve harm reduction services in prisons, for many people in prison with histories of drug use, imprisonment offers little rehabilitative value.

People with drug dependency would be better served by community-based responses which address the root causes of criminal behaviour, are more successful in reducing reoffending, cheaper than imprisonment and do not increase health risks.[133] Both the UN System Common Positions on drugs and on incarceration recognise the need to reduce the use of imprisonment, and more UN human rights experts and treaty bodies are urging countries to adopt decriminalisation and alternatives to prison to protect the human rights of people who use drugs.[134]

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