Dr Edwards
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United Nations
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Dear Dr Edwards,

I am writing to you in response to your call for submissions on prisons. I am a Professor Medicine, UNSW, Australia and have been studying prisons since 1987. I have conducted 104 studies, received $(Aus) 39 million in funding and have 280 publications (189 peer reviewed articles). I have conducted research or training in prison in 17 countries (Australia, UK, Liberia, Russia, Malaysia, Myanmar, Indonesia, Philippines, Cambodia, Thailand, Laos, Vietnam, Egypt, India, Nepal, China, and Iran).

I have written policy documents on prisons for UNAIDS, UNODC, WHO and Population Services International. I am an expert in the following areas of prison research; drug use and treatment, infectious diseases, reviews of prison medical services and women. I am a member of the Irish Office of Inspectorate of Prisons *and* the Council of Europe's Committee for the Prevention of Torture, although I have not made any visits for either organisation yet.

I am making this submission as a Board Member of Harm Reduction Australia (HRA), a national organisation committed to reducing the harms potentially associated with drug use and drug policy responses [Home - Harm Reduction Australia].

I can provide the reports on my work in Liberian prisons as they are not readily available. However, I would ask that you do not cite this reference as it rather critical of Liberia,

> *Dolan, K. A situational assessment of health-related services in the prison setting in Liberia, Population Services International, Sydney, 2017a.*

However, you could cite my other two reports on Liberia, which provide a guide to providing prison health care in a resource poor setting.

I am happy to review any sections that cover my areas of expertise.

Yours sincerely

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Contents

The Global Prison Population

Globally, at any given time, there are over 10 million people held in prisons and between 2.5 and 3 million of these are held in pre-trial detention. However, turnover in the prison populations is thought to be at least 3 times that with some 30 million individuals being detained and released into the community each year. Most prisoners are male who account for about 90% of this population (1). The prevalence of drug use disorder in prisoners ranges from 10% to 61% in men and 30% to 69% in women (2), whereas the community prevalences range from just 0.6% to 4.0% in men and just 0.3% to 2.9% in women (3).

Measures to reduce overcrowding: Reduce the number of prison entrants.

1. Drug-dependent offenders have very high rates of incarceration.

Drug offenders account for 3–29% of prison inmates in the EU, 4–29% of inmates in non-EU European countries, 5–53% of inmates in the Americas and 10–58% of inmates in Asia/Oceana (4). In the USA, between 24% and 36% of all heroin dependent persons pass through the corrections system each year, representing more than 200,000 individuals (5).

2. Drug-dependent offenders have very high rates of *reincarceration.*

Relapse and re-offence are usual after release from prison. In the USA, for example, drug-use relapse rates are more than 80%, and the 3-year re-arrest rates are consistently around 70%. From 1996 to 2006, the general population of the USA increased by 13% while the imprisoned population increased by 33%, and the proportion of prisoners with a drug problem increased by 43% (6).

Drug-dependent offenders are more likely to return to prison than other offenders. In the USA, over 50% of drug-dependent inmates have a previous imprisonment compared with 31% of other inmates. In New South Wales, 84% of heroin-dependent inmates were re-imprisoned within 2 years of release, compared to 44% of all prisoners (7). Australians who inject drugs reported an average of 5 imprisonments (8). These high rates indicate that most drug offenders do not receive treatment while in prison nor are they being referred to treatment on release.

3. Introduce alternatives to incarceration for drug offenders.

International bodies, including the United Nations, are now routinely and openly declaring the war on drugs a failure, and denouncing prohibition as not only ineffective but fundamentally harmful and inhumane. There is now a growing global recognition of the need to urgently move towards the full decriminalisation/legal regulation of the use and supply of currently illicit substances for personal consumption, along with possession for personal use, to address the significant long-term health and financial consequences and the human rights violations that are caused by criminalising, arresting, convicting, and often incarcerating people who use drugs. Further, multiple reports from the Global Commission on Drug Policy (GCDP) – a group of eminent past heads of state and other dignitaries – have reiterated their

collective view that drug prohibition has failed both the world and individual countries utterly, and that significant drug policy reform is a matter of global emergency (9).

Additional benefits of providing evidence-based drug treatment in prison

If people incarcerated for drug offences receive evidence-based treatment in prison, there will be reductions in

The transmission of infectious diseases which can be fatal without treatment (10),
Drug-related violence (11),
Fatal and non-fatal drug overdoses during and after prison (12).

4. Transmission of infectious diseases in prison

The Lancet published a series of six papers and three commentaries on prisons and infectious diseases in 2016. The key findings and messages from the Series appears below.

Key findings and messages from the series

Of the estimated 10·2 million people incarcerated worldwide on any given day in 2014, we estimated that 3·8% have HIV (389,000), 15·1% have HCV (1,546,500), 4·8% have chronic HBV (491,500), and 2·8% have active tuberculosis (286,000). Mathematical modelling suggests that incarceration and re-incarceration of people who inject drugs contributes to the overall HIV epidemic and a reduction in incarceration of this population will reduce the incidence of HIV. Evidence-based prevention and treatment such as opioid agonist therapy and antiretroviral therapy can substantially reduce the incidence of HIV, HCV, and HBV, and reduce drug dependence in this population. The most effective way of controlling infection in prisoners and the broader community is to reduce mass incarceration of people who inject drugs (10).

Prevalence of HIV, HCV, HBV, and tuberculosis is higher in prison populations than in the general population, mainly because of the criminalisation of drug use and the detention of people who inject or use drugs. The few studies on incidence suggest that intraprison transmission is generally low, except for large-scale outbreaks. Responses to co-infection with HIV and tuberculosis should include an integrated, patient-centred model of prevention and care, with systematic screening of high-risk groups and equitable access to effective treatment (10).

5. Drug-related violence in prison.

Surprisingly there are few reports on drug-related violence in prison. In NSW interviewees in a qualitative study reported one reason for seeking opioid agonist therapy was that drug-related debts could be avoided (11).

6. Fatal and non-fatal drug overdoses during and after prison.

Incarceration is associated with increased risk of overdose death due to**:**

- A loss of tolerance to opioids

- Limited access to harm reduction and treatment services
- Forced withdrawal when people with opioid use disorder are incarcerated. This dramatically increases the risk that they will fatally overdose if they go back to using drugs after they are released from jail or prison.
- Overdose is the leading cause of death among people recently released from prisons as well as the third leading cause of death in US jails (13).

Women in prison

The International Narcotics Control Board (INCB) is the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions. It was established in 1968 in accordance with the Single Convention on Narcotic Drugs, 1961 (14). It had predecessors under the former drug control treaties as far back as the time of the League of Nations. The INCB's 2016 annual report was on Women and Drugs (15). I wish to draw the reader's attention to their recommendation below.

Excerpts from the report appear below.

> Criminal justice data indicate that an increasing number of women are arrested for drug-related crimes. The incarceration of women involved in drug-related offences may have a catastrophic effect on their children, particularly if they are the primary caregivers. Additionally, female prisoners have very high levels of drug dependence but rarely have access to treatment and rehabilitation services. The proportion of women involved in drug offences is increasing. Over the last 30 years, the number of women incarcerated in the United States for drug-related offences increased by over 800 per cent, compared with a 300 per cent increase for men. Two thirds of women in federal prisons in the United States are incarcerated for non-violent drug offences. In Europe and Central Asia, more than 25 per cent (and up to 70 per cent in Tajikistan) of women prisoners have been convicted of drug-related offences. In Latin America, between 2006 and 2011, the female prison population almost doubled, with 60 to 80 per cent incarcerated for drug-related offences. Women who have little formal education or who lack employment opportunities are those most frequently found to be involved in the drug trade. Most women who are arrested for acting as drug couriers have no previous criminal convictions and many are foreign-born. In Argentina, 9 out of every 10 foreign female prisoners with drug convictions were couriers, and the overwhelming majority were first-time offenders. These female inmates have no family, social or institutional ties to the country in which they are held and are often serving long sentences (15; pp 1 & 2).
>
> INCB recommended that
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> > Countries wishing to reduce the numbers of women incarcerated have the possibility of making use of the provisions of article 3, subparagraph 4 (c), of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 (16), which clearly provides for alternatives to incarceration, stating that "in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures

such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare" (15).

Death penalty for drug offences

Harm Reduction International records executions for drug offences. They reported

As of December 2022, there were **at least 285 executions for drug offences globally during the year, a 118% increase from 2021, and an 850% increase from 2020.** Executions for drug offences are thought to have taken place in six countries: Iran, Saudi Arabia, Singapore, China, North Korea and Vietnam. This figure is likely to be an underestimate. Confirmed death sentences for drug offences were also on the rise; **with at least 303 people sentenced to death in 18 countries. This marks a 28% increase from 2021** (17).

Corporate resistance to death penalties

Some pharmaceutical companies have refused to provide drugs used in prison executions (18). Now the American Institute of Architects approved new ethics rules prohibiting members from knowingly designing spaces intended for execution or torture, including for prolonged periods of solitary confinement (19).

Closed settings (Compulsory Drug Detention Centres)

The continued existence of compulsory drug detention centres, where people who use or are suspected of using drugs and other vulnerable populations are detained without due process in the name of "treatment" or "rehabilitation", is a serious human rights concern. These compulsory drug detention centres (many of which are based in countries in the Asian region) raise multiple human rights issues including the potential for increased exposure to HIV, hepatitis B and C and TB infections (20). Although criteria for detention does vary within and among countries, detention often takes place without the benefit of sufficient due process, legal safeguards or judicial review. The deprivation of liberty without due process is an unacceptable violation of internationally recognised human rights standards. Furthermore, detention in these centres has been reported to involve physical and sexual violence, forced labour, sub-standard conditions, denial of health care, and other measures that violate human rights.

HRA's position on these centres aligns with a growing number of international and national organisations, governments and other entities including the UN family that has issued a joint UN statement calling on States that operate compulsory drug detention and rehabilitation centres to: "…close them without delay and to release the individuals detained. Upon release, appropriate health care services should be provided to those in need of such services, on a voluntary basis, at community level. These services should include evidence-informed drug dependence treatment; HIV and TB prevention, treatment, care and support; as well as health, legal and social services to address physical and sexual violence and enable reintegration. The UN stands ready to work with States as they take steps to close compulsory drug detention and rehabilitation centres and to implement voluntary, ambulatory, residential and evidence-informed alternatives in the community" (20).

Case studies

Inadequate conditions of detention

In 2017, I conducted a situational analysis of the management and delivery of health-related services in Liberian prisons (21), developed standard operating procedural (SOP) guidelines (22), and delivered training on the SOP to 70 staff (23). Key findings are below.

Liberia's prison system faces a multitude of challenges to address the excessive overcrowding, including many inmates who were yet to be sentenced. Other challenges were the general living conditions such as providing sanitation, clean drinking water, ablution and laundry facilities, bedding, ventilation, natural light, and provisions of basic toiletries. It is essential to repair buildings, renovate kitchens, improve diets and remove vermin and mosquitoes. More time out of cells and an opportunity to exercise would improve the mental health of prisoners, which is desperately needed. Inmates are likely to reoffend unless provided with rehabilitation. Resumption of educational classes to improve their employment prospects are urgently needed. There is a need to stock the offices and clinics with essential equipment including basic medical supplies. Simple things like being able to wash one's hands and use a toilet will reduce the transmission of disease between inmates and staff. Inmates were defecating into plastics bags and then throwing them out of the cells.

Electricity needs to be in constant supply and staff members need to be paid in a timely manner. The number of staff needs to be increased dramatically. Inmates have numerous infections that need treatment, especially scabies and STIs. Minority prisoners such as pregnant women and juveniles have special needs that are not being met. There are inexpensive ways to prevent malaria and TB with flyscreens and isolation on entry, respectively.

Effort still needs to be directed at improving the poor co-ordination between county health teams and prison assignments, record keeping and stocking clinics with equipment and medications. These issues are well known to the Ministries of Justice and Health, so presumably funding is the main barrier.

On a positive note, some prisons had gardens where food was farmed or grown but not in sufficient quantities to feed the inmates. Cassava, pineapple and plantain were grown. Some prisons farmed rabbits, chickens and guinea pigs and one prison had a few goats. They were also able to avoid outbreaks of Ebola by using isolation methods for entrants. I suspect these conditions are common to many countries. If a country requests assistance from UNODC, they may provide guidance and some resources. The UNODC is opening an office in the DRC next year which could address some of these problems.

Standard operating procedures: Summary

The Standard Operating Procedures (SOP) manual was developed after a situational analysis of the management and delivery of health-related services in prison settings in Liberia (22). The aim of the SOP is to provide guidance to staff on the delivery and management of health care to prisoners in Liberia. The SOP covers the essential components of health care in the prison setting in a developing country with limited resources. Where possible, these guidelines align with international standards for prisoner health care. Importantly, it is

intended to be achievable within the Liberian prison health service, rather than provide a comprehensive service that addresses every health issue.

There are nine parts to the Standard Operating Procedures manual.

Part 1 - Basic principles in prisoner health care
Part 2 - The medical assessment process
Part 3 - Special groups of prisoners
Part 4 - Equipment and supplies for the prison clinic
Part 5 - Pharmacy services
Part 6 - Health records, data collection, reporting and review
Part 7 - Environmental health and safety
Part 8 - Deaths in custody and compassionate release
Part 9 - Release and linkage to the community

Innovative and good practices

NSW Justice Health and Forensic Medicine is one of the superior prison health service in the world. This Service is independent of the Department of Corrections and instead comes under the auspices of NSW Health Department and therefore follows community guidelines on health care and services. The Mandela rules stipulate that:

Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence (24). It has a Research Unit that aims to continuously improve patient health services by conducting and facilitating high-quality research (25). The Research Unit has conducted two landmark periodic studies: the NSW Inmate Health Surveys of 1996, 2001, 2009 and 2015, and the NSW Young People in Custody Health Surveys of 2003, 2009 and 2015. The information from these surveys has been invaluable to planning and monitoring health services and for funding and advocacy initiatives. It has a state-of-the-art forensic hospital (26).

Prison gardens

My Senior Fulbright Fellowship took me to Kansas State University where I studied the death penalty, solitary confinement and prison gardens. Here I focus on prison gardens.

Studies reveal a positive correlation between the natural environment and stress. Research has shown that being exposed to nature can have a positive effect on one's mental health (27). When gardens have been introduced, there have been physical and psychological benefits for inmates and staff (28).

Some resource poor countries struggle to feed their prison population and a garden that is managed by prisoners would provide purpose, relaxation and a much-needed food supply.

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