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Have prisons learnt from Covid-19?

How the world has reacted to the pandemic behind bars

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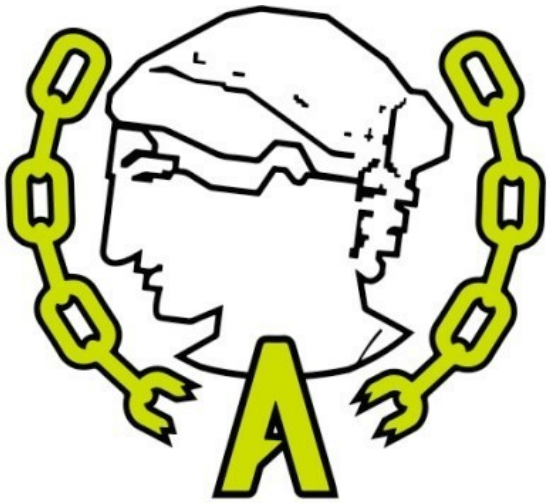

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N. 1/2020 HAVE PRISONS LEARNT FROM COVID-19? HOW THE WORLD HAS REACTED TO THE PANDEMIC BEHIND BARS

edited by Susanna Marietti and Alessio Scandurra

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1. Introduction

The unprecedented and global public health crisis brought about by the rapid spread of Covid-19 has not only dramatically affected the lives of billions of people around the world, but has also placed into sharp relief existing health and social disparities and the need for urgent and radical reforms. As Covid-19 began to spread like wildfire through prisons worldwide, these settings in particular, along with those who live and work within them, came into the spotlight. Their plight sparked impassioned debates on the role of incarceration, punitive drug policies, and systemic discrimination in fuelling the pandemic, as well as the relationship between prison health and public health. Heeding calls from international actors to reduce overcrowding and release prisoners, hundreds of governments began committing to, and implementing decongestion schemes to try to contain the spread of the deadly virus. Months later, however, it is obvious these schemes have been deeply flawed and largely failed to deliver on their promises, revealing governments' preoccupation with punishment over public health - even during a global pandemic. At the same time, those remaining in or returned to prisons continue to be profoundly impacted by the extreme and often disproportionate restrictions imposed in response to the pandemic. These restrictions have in some cases limited their access to essential health services, including harm reduction services, and have led to conditions falling far below humane standards.

2. Health in prisons

Prisons and other places of detention are high risk environments for the spread of infectious diseases like Covid-19. Compared to the general population, people in detention face heightened and unique vulnerabilities, including experiencing a higher prevalence of preexisting health conditions, such as Hiv, hepatitis C, diabetes, high blood pressure, as well as substance use and mental health problems. Prisons are often poorly ventilated and unhygienic, while access to fresh air is severely restricted

and health care services are extremely limited, difficult to access and often of poor quality. In over 64% of all countries, prisons are also shockingly overcrowded, making it virtually impossible to practice physical distancing or self-isolation[2].

With over one third of prisoners returning to their communities every year (S. Enggist *et al.*, 2014), and staff and visitors filtering in and out of prisons on a daily basis, there is a high degree of mobility between prisons and the larger community. The relationship between prison health and public health is therefore an intimate one. Indeed, there are countless documented cases of diseases such as Tb, Hiv and hepatitis C spreading like wildfire through prisons and - inevitably - into the general population (M. Ndeffo-Mbah *et al.*, 2018). Decades of systematic neglect and underfunding of prison health, combined with overcrowding and rigid security processes mean that few, if any prisons, are equipped to provide timely diagnosis and treatment of prisoners in normal conditions, let alone during the current global public health crisis (S.A. Kinner *et al.*, 2020).

With over 11 million people currently imprisoned around the world (Penal reform international, Thailand institute of justice, 2020), it is no wonder prisons quickly became epicentres for the spread of Covid-19, posing unprecedented challenges for governments and prison authorities. Not only did this expose the public health risks of poor and overcrowded prison conditions worldwide, but also called attention to the huge number of people in detention for non-violent offences, and to the punitive and racist policies that drive incarceration.

3. Mass incarceration and the *War on Drugs*

Of the 11 million people currently behind bars worldwide, close to half a million people are incarcerated for mere drug possession, with an additional 1.7 million incarcerated for other drug offences, many of which are non-violent (Un system coordination task team on the implementation of the Un system common position on drug-related matters, 2019). That means that about 21% - or over 1 in every 5 prisoners worldwide - are being held on a drug charge, and this does not take into account the staggering half a million people who are held in involuntary drug detention centres across Asia alone (K. Lunze *et al.*,2018). These figures raise serious concerns over the role of punitive drug policies in driving incarceration, prison overcrowding and the overrepresentation of people who use drugs in prisons and other places of detention worldwide.

The role of the war on drugs and the criminalisation of people who use drugs in driving the Hiv epidemic inside and outside of prisons worldwide has been well documented (Global commission on drug policy, 2012). While some very limited measures have been taken to address this and other epidemics among prison populations, including the very sparse provision of harm reduction services within some prisons for people who use drugs, these measures continue to fall far short of what is required (Harm reduction international, 2020b). They also ignore the root causes of the problem, namely the punitive and racist policies that drive incarceration and make it harder for people to access health and social services. The same is once again

true in the context of Covid-19.

Covid-19 has not only placed a spotlight on the intersection between drug control, incarceration and prison health, but it has also cracked wide open the structural and systemic racism and discrimination that permeates the criminal justice system, and how all of these issues converge to create the perfect conditions for Covid-19 to thrive. Indeed, while Covid-19 sweeps across the globe, so too do protests against violence and racism by the police, highlighting the enduring legacy of racist and punitive policies, including the drug war, in fuelling ill-health and carceral systems worldwide (B. del Pozo, L. Beletsky, 2020). Not only are racial minorities disproportionately affected by Covid-19 and its social and economic impacts (T. Kirby, 2020), they are also much more likely to be stopped, searched, arrested, convicted, and harshly sentenced for drug crimes than their white counterparts all over the world (Working group of experts on people of African descent, 2019). The colliding and disproportionate impacts of Covid-19 and the drug war on the health and well being of racial minorities are a stark reminder that enduring racial disparities and race-based outcomes are directly related to policy priorities that are grounded in discrimination and racial stereotypes (Working group of experts on people of African descent, 2019).

4. Responding to Covid-19: prison decongestion measures

When Covid-19 was identified as a global pandemic in March 2020, international actors from around the world began calling on states to enact emergency measures to address and contain the spread of Covid-19 in prisons (Un High commissioner for human rights, 2020; Unodc *et al.*, 2020). Recognising that alternatives to deprivation of liberty were imperative in situations of overcrowding and even more so in cases of emergency (Commissioner for human rights of the Council of Europe, 2020), a chorus of voices urged governments 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 (D. Puras, 2020). Governments the world over heeded these calls and began committing to and implementing decongestion schemes. This generated hope that much needed reform might be possible, one that reconsiders the legal architecture of drug policy and policing around the world, as well as the necessity and proportionality of criminalisation and incarceration, and chooses instead to prioritise health, racial justice and human rights. Months later, it has become glaringly obvious that this has so far been grossly misconceived.

According to research conducted by Harm reduction international, 109 countries and territories adopted a variety of decongestion schemes between March and June 2020 in an effort to curb the potential spread of Covid-19 within prisons (Harm reduction international, 2020a). The main measures introduced included early releases, often through sentence commutation, pardons, diversion to home arrest and release on bail/parole (Harm reduction international, 2020a). Eligibility for release from prison was largely determined by length of sentence

remaining, age, and preexisting health conditions. By 24 June 2020, these schemes had resulted in the release of approximately 639,000 people, a mere 5.8% of the global prison population (Harm reduction international, 2020a). While this was a welcome initial response, efforts have fallen far short of the significant political commitments made in the name of public health at the peak of the pandemic. Moreover, it is now clear that the effectiveness of these schemes was obstructed by serious design and implementation flaws, bureaucratic hurdles and a lack of political commitment, ultimately revealing an overarching preoccupation with punishment over public health (G. Girelli, 2020).

In terms of release criteria, type of offences was worryingly found to be a significant and recurring criterion for *exclusion* from release in many countries. People convicted of violent crimes, drug offences, terrorism, and political prisoners were largely excluded from early release (Harm reduction international, 2020a). Not only does this reveal the arbitrary nature of these decisions, but it also demonstrates that - even in the face of a global pandemic - many countries continue to prioritise punitive approaches to drugs and other social and health issues over individual and public health. At least 28 countries - over 25% - explicitly excluded people detained for certain drug offences, regardless of whether they met other eligibility criteria (Harm reduction international, 2020a). Sri Lanka was particularly restrictive, in that it excluded from eligibility not only individuals convicted of drug possession and trafficking, but also prisoners *addicted to drugs* (Y. Perera, 2020). In 19 countries, people in pre-trial detention were explicitly excluded; while in some countries, such as Albania and Turkey, decongestion measures only considered prisoners with a final sentence, thus excluding incarcerated individuals who should be presumed innocent (Harm reduction international, 2020a). At least 10 countries excluded prisoners who did not have a fixed home address. Although justified in some cases as a means of preventing homelessness, this stipulation further disadvantages and marginalises some of the most vulnerable prisoners. It also ignores longstanding and serious problems with the re-entry process, including lack of housing and employment opportunities (Harm reduction international, 2020a; M. Fikru, 2020).

In some countries (including Belgium, Columbia, Costa Rica and Iran) release measures were or continue to be temporary, meaning that prisoners have to or are expected to return to prisons when the emergency is over (Harm reduction international, 2020a). In Iran, for example, the country held up as a shining example of successful prison decongestion, thousands of prisoners were called back to prison in late spring, many without following proper quarantine procedures (Abdorrahman Boroumand centre for human rights in Iran, 2020). Not only is this shortsighted, especially considering the second wave of Covid-19 currently sweeping across the world, but it misses an important and unique opportunity to swiftly address prison overcrowding.

Implementation of decongestion schemes has been poor in many countries. In the Uk, for example, although the government committed to release 4,000 prisoners in

April, only 242 were released as of 17 July 2020, of whom 50 were compassionate releases of vulnerable prisoners, pregnant women and mothers with babies (Uk Ministry of Justice, 2020). In Mexico, none of the people released from prison were freed pursuant to the amnesty law adopted in response to the spread of Covid-19, but rather through pre-existing mechanisms because of some an oversight mechanism was never put in place. In Cambodia, the Interior minister announced plans in May 2020 to release around 10,000 individuals from the country's heavily overcrowded prisons - however, at the time of writing it still remains unclear whether anyone has been freed (Amnesty international, Cambodian league for the promotion and defence of human rights, 2020).

Despite a few isolated examples of efforts to reduce arrest and detention, most countries continued to arrest people during the emergency, including for non-violent crimes and other offences that posed no threat to the public, such as non-violent drug crimes (Harm reduction international, 2020a). In Iran, for example, drug use accounted for 7,702 arrests between June and August 2020 in the Tehran province alone (Abdorrahman Boroumand centre for human rights in Iran, 2020). On top of the fact that there is no evidence that incarceration reduces drug use and trafficking, such arrests inevitably interfere with decongestion efforts, and invalidate the thousands of early releases and pardons specifically issued for that purpose (Abdorrahman Boroumand centre for human rights in Iran, 2020).

Finally, there appear to have been very few measures put in place to protect the health and well being of those urgently released back into the general community. Recently released prisoners are particularly vulnerable and require wraparound services, including access to essential health services and housing security. Sudden release, combined with a limited functioning of community-based services during Covid-19 times has made, at least initially, referrals and liaison difficult.This type of disjunction can result in the disruption of treatments like Opioid agonist therapy (Oat)[3] and of comorbidities such as Hiv and hepatitis C, with severe effects on individual and public health (A. Ghosh, 2020). Early into the pandemic, the Un Special rapporteur on the right to health and other Un experts called for effective measures to be put in place, and adequately funded, to ensure that those released from prisons and other detention settings have continuity of care, access to adequate housing and health care in the general community (D. Puras, 2020).

Nevertheless, reports are now emerging from civil society around the world revealing the scale and impact of these calls being ignored. In Iran, for example, many individuals from disadvantaged socioeconomic backgrounds were not linked to adequate financial, harm reduction, and housing support post-release from prison (M. Alavi *et al.*, 2020). Furthermore, among many people without stable housing, the closure of parks following lockdown limited their access to water and sanitation facilities (M. Alavi *et al.*, 2020). In India, scores of people released from prison were forced to walk, hitchhike or cycle hundreds of kilometres to get home and faced stigma and discrimination from their families,

communities and current or potential employers (P. Pundir, 2020). On top of these vulnerabilities, people who use drugs being released from prison also face an increased risk of opioid overdose arising from decreased tolerance to opioids and/or erratic access to Oat, which would be particularly acute during lockdown. While no information could be found on rates of overdose among people who use drugs recently released from prison through decongestion schemes, the general lack of planning to ensure their safety and wellbeing, as well as the shocking scarcity of naloxone for prisoners' on release under normal circumstances (Harm reduction international, 2020b), suggest that an increase in opioid overdose deaths during this period is likely. Indeed, generally speaking, opioid overdose deaths have surged in both Canada and the United States during the pandemic, with the United States recording a national jump of 18% in March, 28% in April and 42% in May (A. Coletta, 2020; W. Wan, H. Long, 2020).

5. Impact of Covid-19 responses on conditions of detention

For the millions of people who remain inside prison or were called back to prison after being temporarily released, there have been significant changes to their conditions of confinement, as well as to the limited services that are generally available to them. For many, prison lockdowns have meant even more extreme restrictions on their lives, leading to conditions in several countries falling far below a humane standard.

In many countries, a complete lockdown was imposed in prisons, with people confined to their cells for 23 hours a day, sometimes more. The suspension of all prison visits, along with recreational and occupational activities, were often rigidly imposed, sometimes in a blanket fashion, while a commitment to video calls often went unimplemented meaning individuals could not even maintain contact with their legal representatives and families. Routine inspection visits were also suspended, while the use of restraints and solitary confinement were extended. In many countries jury trials were suspended and court hearings were delayed (T. Hewson *et al.*, 2020). Resource and staff shortages disrupted the ability to maintain even a basic regime where people could use the toilet, shower or make a phone call, let alone access essential health services. These measures have had a devastating impact on the mental and physical health of people in prison. They have also lead to rising tensions (Office of the correctional investigator of Canada, 2020) and an increase in prison riots; in Italy, prison riots emanating from Covid-19 restrictions resulted in the death of 13 prisoners, most from overdosing on drugs allegedly taken from prison clinics during the riots (National guarantor for the rights of persons detained or deprived of liberty, 2020). They have also intensified the risk of human rights abuses. As aptly pointed out by the Joint committee on human rights in relation to the human rights implications of the Uk government's response to Covid-19, legitimate questions remain as to whether the severe restrictions imposed in prisons were proportionate and whether lives could have been protected by other, less restrictive means, including through more extensive and responsibly managed early release schemes (Joint committee on

human rights, 2020).

6. Provision of harm reduction in prisons in times of Covid-19

Like in the broader community, the redeployment of resources and staff to support Covid-related health services disrupted other critical health services, including harm reduction services, in prisons. As highlighted by numerous public health and human rights bodies and experts, states have an obligation to continue to provide essential health services to prisoners, including harm reduction measures, during the pandemic (D. Puras, 2020). Yet civil society reports reveal that some prisons currently do not even have doctors, while lack of funding threatens the continued availability of medicines in others (Eurasian harm reduction association, 2020).

Information on the availability and accessibility of harm reduction services in prisons is notoriously scarce, and the situation is no different in the era of Covid-19. This is a serious problem that continues to require urgent action. The little information currently available on the provision of harm reduction in prisons during Covid-19 reveals no real trends; the situation simply varies from country to country. In some countries, services appear to have continued despite other Covid-19 related restrictions being imposed. In Georgia and Estonia, for example, civil society reports that Oat has continued to be provided to prisoners on a regular basis without any problems documented (Drug reporter, 2020). Similarly, in Bosnia and Herzegovina, Oat reportedly continues to be available, but the use of masks and disinfectants have become a requirement to use this service (Eurasian harm reduction association, 2020).

In other countries, services have either been abused, interrupted or suspended. In Moldova, a country heralded as one of the best in the world in terms of harm reduction provision in prisons, the provision of Oat has reportedly been suspended in two prisons because authorities have distributed the medication among themselves, and interruptions in the availability of antiretrovirals have also been reported (Eurasian harm reduction association, 2020). In Lithuania, guards are reportedly threatening to revoke prisoners' access to methadone as a means to assert control and suppress conflicts arising during the lockdown (Drug reporter, 2020). Civil society also report that the provision of Oat was suspended in prisons in Kyrgyzstan (Eurasian harm reduction association, 2020). In Canada, restrictions were imposed on almost all programming in prisons in March 2020. Yet according to the Correctional Service of Canada, the *Prison needle exchange program* (Pnep) continued in the prisons where it was already being provided, while its promised rollout has remained suspended since March (B. Graveland, 2020). Even before the lockdown, many - if not most - people in prison who inject drugs were not accessing the programme because of its inherently flawed nature, which includes approvals by health and security staff, as well as the institutional warden, before individuals can participate[4]. While it has been difficult to gather reliable data on Pnep uptake since March due to strict limitations on prison visits, civil society maintains it is safe to assume that numbers remain very low due to significant

restrictions on programming that occurred at the onset of the pandemic, on top of the confidentiality concerns and other barriers to access which have yet to be addressed[5].

In some other regions, harm reduction services appear to have been adapted to safeguard the health of people who use drugs in prison. In Scotland, for example, where approximately 25% of the people in prisons receive a daily dose of Oat (methadone), a decision was taken early on to switch to the use of depot buprenorphine (Buvidal) for all people currently on methadone in prison serving sentences of six months or longer (G. Smith, 2020). Available as 7-day or 28-day injection, depot buprenorphine helps to ensure continuity of Oat while the Covid-19 restrictions are in place and minimises contact with frontline healthcare staff. Ministers and the Scottish Government's Health finance planning and assurance group agreed emergency funding of up to £1.9 million for Health boards to cover the cost of transferring methadone administration to Buvidal in prisons for an initial four month period (May-August 2020), and a step-by-step approach was put in place to ensure a careful transition for those who require it (Scottish Government, 2020). Similarly, in the Australian state of New South Wales, a suspension of prison visits resulted in a reduction of illicit drugs available in the prison, which led to an increase in demand for Oat among prisoners. While some people were already receiving depot buprenorphine (Cam2038) before the lock-down following a successful trial in late 2019, everyone else receiving a different form of Oat during lockdown was transferred onto depot buprenorphine to reduce the resources needed for Oat delivery and increase availability of staff for other clinical activities (J. Roberts *et al.*, 2020). Although these approaches are commendable in many ways, the exclusion of people serving shorter sentences or not currently on Oat but who might now wish to be in Scotland appears arbitrary and is more than likely a violation of their human rights.

According to widely accepted international standards on the treatment prisoners, states have an obligation to provide a standard of care that is at least equivalent to that available in the broader community, commonly known at the *principle of equivalence*. Some experts, however, have rightly questioned whether the aim should not be equivalence of care, but rather equivalence of objectives and results, which would require a higher standard of care for prisoners (R. Lines, 2006). This idea is particularly relevant in the current climate, which has served to accentuate the unique risks that people in prisons and other detention settings face.

7. Conclusions

The Covid-19 pandemic has exposed for all to see the particular vulnerabilities of people in prison, as well as the shocking conditions they are forced to live in. It has clearly demonstrated how intimately connected prison health is to public health. It has also laid bare the fact that people who use drugs and racial minorities are not only disproportionately represented in prisons globally, but also disproportionately impacted by Covid-19. These uncomfortable truths have forced a spotlight onto the role of incarceration, punitive drug policies, and systemic discrimination in fuelling the pandemic,

and other health and social crises, revealing just how fundamentally flawed punitive policies like drug enforcement are, as well as criminal justice systems the world over. With decongestion schemes rolled out globally in an effort to curb the spread of the virus, doubts were cast on the necessity and proportionality of incarceration in the first place, raising hopes that this may be an entry point to consider and begin putting into place much needed reforms. Indeed, the current public health crisis has provided a once-in-a-century opportunity. An opportunity to recognise, as anthropologist Thurka Sangoramorthy points out, "how the deepening disparities generated in the context of Covid-19 are not anomalies, but rather systematic, productive, generative and valuable to the operation of governing bodies and the management of populations" (T. Sangaramoorthy, 2020).

Unfortunately, the significant shortcomings of the decongestion measures make it patently clear that governments have missed this opportunity and continue to prove unable to prioritise individual and public health over punishment, one more piece of evidence that major structural reforms are needed, rather than just piecemeal measures. And the disproportionate response to Covid-19 in prisons confirms that holistic and human rights-based considerations and approaches often continue to be eclipsed by heavy-handed approaches. Tackling the current global health crisis requires much more than just a health and safety response; it requires both short and long-term solutions that involve fundamentally rethinking ineffective and harmful policies. Punitive and discriminatory drug laws and policies that currently fuel mass incarceration and intensify global inequality, sickness, poverty and exclusion must be urgently reformed. Alongside this transformation must be a fundamental overhaul of the criminal justice system, including defunding the police and urgently addressing the crisis of prison overcrowding. Resources currently invested in drug enforcement, which have for far too long crowded out proven measures to address drug-related harms, must be urgently reallocated to dedicated systems of care and support which strive to promote dignity, human rights, and racial justice. These may seem like big demands in a system structurally built to oppress some and benefit others, but they are essential. Covid-19 presents a rare opportunity to live up to the challenge to adapt to a new reality and build a better world, and it must be seized and acted upon before it is too late.

Notes

[1] **Gen Sander**: is a Human rights analyst at Harm Reduction International (HRI). Prior to that, she was a senior researcher at the Essex Human Rights Centre, where she worked with Prof. Paul Hunt, former UN Special Rapporteur on the Right to Realth, on issues relating to health and human rights, and taught a module on international human rights law. She has worked with various human rights NGOs in Canada, Europe and the Middle East, and has also been a consultant for the WHO and the Independent Expert Review Group (IERG) on right to health issues.

[2] World prison brief, Institute for crime and justice policy research, Birkbeck University of London, *Highest to lowest - occupancy level (based on official capacity)* https://www.prisonstudies.org/highest-to-lowest/occupancy-level?field_region_taxonomy_tid=All (accessed on 16 September 2020).

[3] Oat (also referred to as Ost, Otp or Mmt) is the prescription of an opioid agonist substance with similar pharmacological action to the drug of dependence. It present a lower degree of risk than opioids purchased on the street. Examples of Oat include methadone and buprenorphine, which are on the Who's list of essential medicines, and are two of the most widely used, evidence-based treatment for opioid dependence around the world.

[4] See the statement by 70 organisations Canada-wide (2019), *Correctional service of Canada must fix fundamental flaws with prison needle exchange program* http://www.aidslaw.ca/site/wp-content/uploads/2019/08/PNSP-2019-Organizations-Statement-2.pdf (accessed 24 September 2020).

[5] SandraKa Hon Chu (22-23 September 2020), *Personal communication, on file with author.*

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