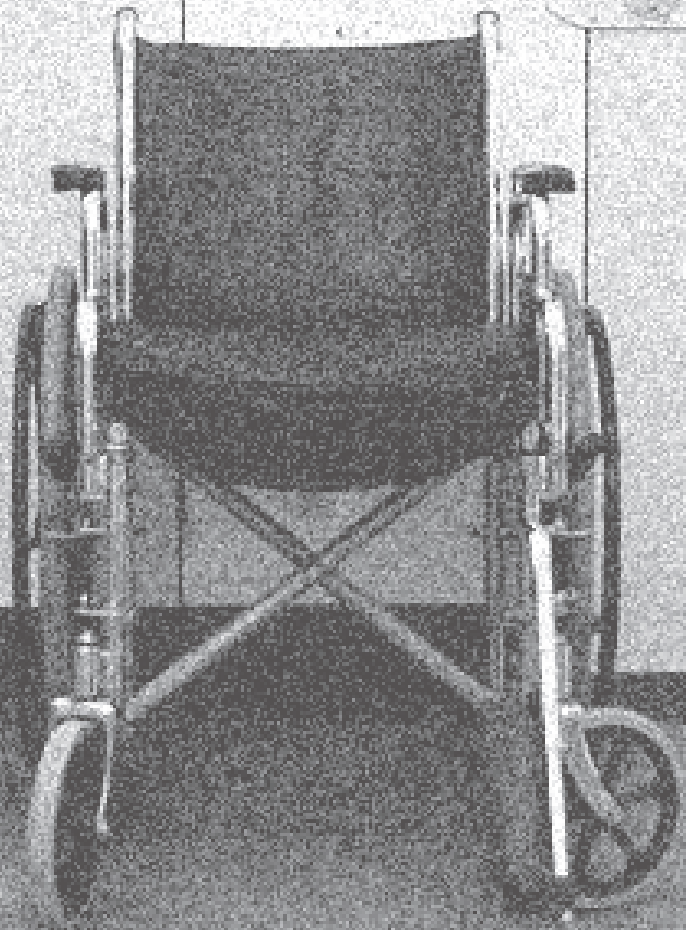




# **TOWARDS A HEALTH-INFORMED APPROACH TO PENAL REFORM?**

**EVIDENCE FROM TEN COUNTRIES**

**CATHERINE HEARD  
JUNE 2019**



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**Catherine Heard**

**Director, World Prison Research Programme**

**Institute for Criminal Policy Research**

**June 2019**

# Foreword

In April 2015, when South Africa was 21 years into democracy, I visited Pollsmoor Remand Detention Facility in the Western Cape. It is a justly famous institution, for Nelson Mandela, later first President of democratic South Africa, had been imprisoned there from 1982 to 1988. At the time of my visit, Pollsmoor was operating at around three times its official capacity. Mine was the third inspection visit by a Justice of the South African Constitutional Court in fewer than five years. These earlier inspection reports made clear demands for essential improvements. They did not take place. My team and I were confronted with scenes of human degradation and suffering similar to those my colleagues had earlier witnessed. Worse: the symbolism of imperfect transition, of imperfect realisation of our post-apartheid aspirations was all too anguishingly present.

The physical conditions to which several thousand remand prisoners were being subjected were potently distressing. They were causing grave damage to the prisoners' mental and physical health. The cells were desperately overcrowded, filthy and dark. Standards of sanitation were appalling, as was the smell inside the airless communal cells. There was no hot water and insufficient space for sleeping. Windows were broken and blankets were dirty and lice-infested. The conscientious prison doctor confirmed to us, when we visited the prison's clinic, that scabies and lice infestations were prevalent. In addition, serious staff shortages created risk of harm to staff and inmates.

Many of the prisoners we saw were very sick. Inmates showed us injuries and infections. They had received no treatment. The doctor lacked essential supplies to treat skin infections and other illnesses. The prison pharmacy would often run low on medication for tuberculosis, hypertension and diabetes, as well as penicillin. Prisoners had contracted leptospirosis, a potentially fatal disease carried in the urine of rats.

The visit left no doubt that the situation at Pollsmoor and other prisons left the South African government and correctional services vulnerable to constitutional challenge in the courts. And so it transpired. After my report was published in July 2015, a group of civil society organizations that had been calling for change for years formed the Detention Justice Forum. In September, a member of this group, Sonke Gender Justice, instituted proceedings against the government and the head of Pollsmoor. The High Court ordered the respondents to take immediate steps to reduce overcrowding and to improve conditions. These orders began to take effect in the months that followed.

As the research presented in this report reveals, there is still some considerable distance to travel before prison overcrowding begins to be adequately addressed in South Africa. Sadly, overcrowded prisons and unhealthy prison environments blight the justice systems of far too many countries. The Institute for Criminal Policy Research (ICPR) has gathered disturbing evidence from across the five continents, including first-hand descriptions by people who have endured the misery of cramped, unsafe, disease-ridden jails.

Across almost all the countries represented in ICPR's study, the same tragedy is playing out – prisons filled to overflowing with people who have been cast out by society, stigmatised because of their mental or physical health problems, their drug or alcohol addiction, their homelessness. And, in the case of remand prisoners, like many of those at Pollsmoor, penalised severely because they are poor – because they cannot afford bail money.

The implications – for public health and for the safety of our communities – could not be more serious. So why does this state of affairs persist?

In my own country, political choices have played a big part in thrusting us into mass incarceration with all its bleak and unproductive consequences. Mandatory minimum sentencing laws passed in the late 1990s drove up the length of prison sentences. They vastly increased the number of people serving very long custodial terms and particularly life sentences.

At the same time, those in power – and I include judges, who also enjoy power, and bear responsibility – have paid too little attention to tackling poverty, social exclusion and health inequality. All of these contribute to the over-criminalisation of marginalised people. Populist 'law and order' policies have not only led to quick and easy recourse to imprisonment. They have also created a climate that denigrates the human right to dignity of prisoners.

In this climate, we judges have a key role in upholding constitutional rights, including in relation to prison conditions and healthcare. This was made clear in 2011, when the United States Supreme Court ruled that

the State of California must end its decades-long mass incarceration policies. In *Brown v Plata*, the majority held that a court-enforced population limit was essential to secure prisoners' rights against cruel and unusual punishment. 'Prisoners retain the essence of human dignity inherent in all persons', the court said; and judges have a responsibility to remedy violations of the constitutional prohibition against cruel and unusual punishment. This extends to the provision of healthcare. The decision ended a long tradition of federal courts simply deferring to correctional authorities. The Supreme Court emphatically affirmed the judiciary's role in protecting prisoners' rights in the face of ongoing and persistent constitutional violations by prison authorities in relation to healthcare.

This report examines the effects of failed penal policies through the lens of health. The evidence it dispassionately presents is powerful and at times moving and distressing. The report makes a compelling case for re-shaping our justice and health policies to ensure that society's most vulnerable citizens are better protected. I am confident that ICPR's wider project examining the use of imprisonment in ten countries – of which this report forms part – will contribute to our understanding of the causes and consequences of the misconceived over-use of imprisonment. More importantly, it will help us to achieve lasting change.

**Edwin Cameron**

**Justice of the Constitutional Court of South Africa**

## Summary

In the year 2000, the world's prison population numbered around 8.7 million; less than two decades on, it stands at well over 11 million. The steady growth in prisoner numbers has given rise to severe prison overcrowding in much of the world, in both developed and less developed countries. Our World Prison Brief data show that prison systems are now overcrowded in well over 60 per cent of the world's countries.

When prison population growth is not matched by increased investment in built capacity, staff and other resources (as it almost never is), living conditions quickly deteriorate, as do standards of sanitation, healthcare, wellbeing and safety. The consequences for health – not only the health of prisoners and staff but also of their families and wider society – are serious.

### Prison as both site and cause of ill health

People who enter prison are already more likely to have poor health than the general population. This reflects the fact that prison populations are disproportionately made up of people who come from the poorest and most marginalised sections of society, where prevalence of mental and physical health problems tends to be greater and health inequality more marked. In addition, in most societies today it is all too easy for people with mental health conditions, or who are dependent on drugs or alcohol, to be propelled into the criminal justice system and custody.

Prisons carry heavy burdens of both communicable and non-communicable diseases, burdens they are ill-equipped to bear. Although imprisonment occasionally allows people who otherwise have no access to healthcare to receive some treatment, time spent in custody is far more likely to worsen existing health problems and give rise to new ones. Prisons are also difficult settings in which to provide treatment and healthcare. They are even less capable of meeting the complex health needs of the many prisoners who have specific vulnerabilities: older prisoners, women, young prisoners, people with disabilities, LGBT prisoners.

This report contains many descriptions by prisoners and former prisoners of cramped, insanitary conditions and unsafe environments where distress, trauma, self-harm, anxiety and violence are the norm. These accounts attest to the damage that prison so often causes to people's physical and mental health. They describe living conditions where inmates cannot even count on the basics: drinking water, proper toilets, cleaning materials, food, and sleeping space. Prisoners describe their struggles to access medication and treatment, even for serious conditions like diabetes, tuberculosis and HIV. Mothers with infants in prison describe how their children regularly fell ill with diarrhoea, cholera and skin diseases. The sleeplessness, anxiety, confusion and fear that prisoners experienced in custody continued long after their return to the community.

A sentence of imprisonment is a sentence of deprivation of *liberty*, not of damage to health. States running prison systems that leave people in worse health than when they entered custody cannot expect prisons to achieve rehabilitation or make communities safer. They will simply perpetuate the revolving door of ill health, unemployment, poverty, homelessness – and repeated arrests and prison sentences.

Governments that fail in their duty to protect prisoners' physical and mental health and provide adequate health treatment and decent, humane conditions create unacceptable public health and security risks. This leaves them open to legal challenges for infringing fundamental and constitutional rights.

### Towards a health-informed approach to penal reform

For most countries, reducing prisoner numbers overall is an essential first step to improving conditions of imprisonment and increasing access to healthcare and treatment for those in custody. This requires reform at the criminal justice level and more broadly. (This is the focus of our wider prisons research, though not of this report.)

A key part of reducing overall prison populations is to take every available step to reduce the numbers of people with mental health conditions who enter custody. We give examples of interventions capable of diverting people

into support and treatment from the earliest point at which they are involved with police. At the other end of the spectrum, we discuss the largely hidden problem of prisoners who develop dementia and other age-related cognitive impairments – an inevitable consequence of the use of ever-longer sentences in many countries.

Taking a public health approach to penal reform means recognising the way in which societal disadvantage and marginalisation raise the risk of involvement in criminal justice processes. It means seeking to address that risk by providing more effectively for health needs in the community, particularly those linked to mental health and drug or alcohol problems. It also means that, for those reduced numbers for whom custody is inevitable, there is proper access to healthcare, screening and treatment; prisoners' health and wellbeing are promoted; and harm reduction measures are in place to minimise risks to the health of prisoners, staff and the wider public.

As Justice Cameron makes clear in his Foreword, the state of a country's prison system is ultimately the result of political choices. It will take considerable political will to put in place the policies needed to end our over-reliance on criminal justice interventions and accept that other approaches, focused on tackling social injustice and health inequality, are more likely to reduce crime and improve public health.



# 1. Introduction

The world's prison population has risen substantially in recent decades and now stands at well over 11 million. In much of the world, increases in prison populations have not been matched by additional built capacity or greater investment in staff and other resources. This has led to overcrowded and unhealthy environments, with cramped living spaces and reduced access to the basic minimum requirements for human health: natural light, fresh air, drinking water, sanitation, food, medicines and treatment. Well over 60 per cent of countries have overcrowded prison systems today.<sup>1</sup>

People in prison retain their fundamental right to enjoy good health. They are entitled to a standard of healthcare equivalent to that provided in the wider community. When the state deprives people of their liberty, it takes on a responsibility to look after their health, by ensuring safe, healthy living conditions and by meeting treatment needs. The reality, sadly, is very far from this. Prisoners often arrive in prison with pre-existing mental and physical health problems, including untreated (perhaps undiagnosed) medical conditions. Poor material conditions and lack of healthcare cause these problems to worsen and can give rise to new health problems, among staff as well as prisoners.

The consequences of overcrowded, under-resourced prisons for public health are serious, particularly as regards communicable diseases, mental illness, substance misuse and increased risk of violence, self-harm and suicide. The risk of harm exists not only for the millions of people (staff and prisoners alike) who spend time in overcrowded prisons around the world in any given year, but also for their families and wider communities. Damage to prisoners' health also undermines prospects for rehabilitation and desistance from offending. Yet despite their severity and impact, the health risks presented by the over-use of imprisonment and by overcrowded, under-resourced prisons rarely figure in public or political discourse.

## 1.1 Background

This report aims to provoke fresh consideration of the health risks associated with the over-use of imprisonment and to explain why addressing them should be regarded as a policy priority. It draws on data collected for ICPR's international, comparative project, *Understanding and reducing the use of imprisonment in ten countries* ('the ten country project'), which was launched in 2017.<sup>2</sup> The project examines the use of imprisonment in the following diverse group of countries spanning all five continents:

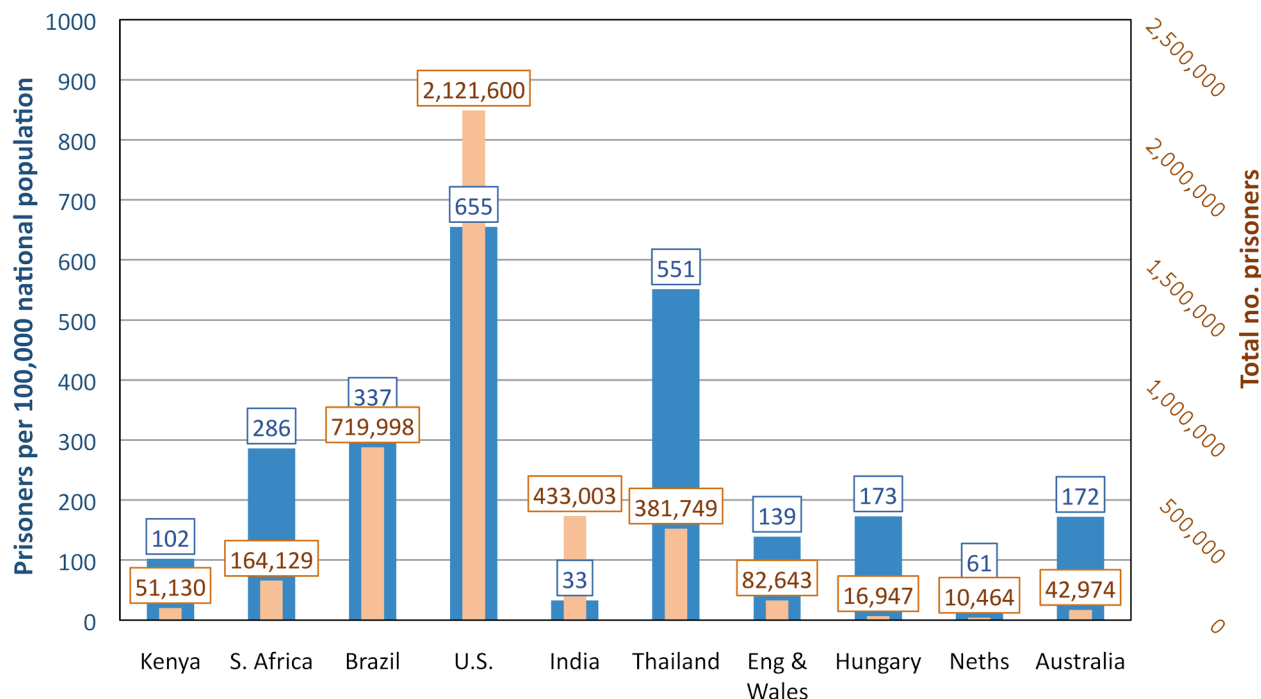
- Kenya and South Africa in **Africa**
- Brazil and the United States in the **Americas**
- India and Thailand in **Asia**
- England and Wales, Hungary and the Netherlands in **Europe**
- Australia in **Oceania**

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1 Data on prison populations and (where available) national prison systems' official capacity are available on the World Prison Brief website, hosted and published by the Institute for Criminal Policy Research (ICPR): <http://www.prisonstudies.org/>. The extent of global prison overcrowding is described in section 3.2.2 below.

2 The project's first report (Jacobson et al, 2017) presented brief accounts of the ten countries' recent patterns of imprisonment. The report showed that of the ten countries, only one – the Netherlands – has achieved a significant reversal in the upward trend, with a sustained reduction in prisoner numbers, although steady falls have also been seen in American prisoner numbers since their peak in 2008. The report can be accessed here: [http://www.prisonstudies.org/sites/default/files/resources/downloads/global\\_imprisonment\\_web2c.pdf](http://www.prisonstudies.org/sites/default/files/resources/downloads/global_imprisonment_web2c.pdf)

**Figure 1: Prison population rate (number of prisoners per 100,000 of the national population) and total prison population for countries featured in the ten country project\***



\*Most recent figures available on World Prison Brief database as of May 2019. Figures vary by jurisdiction as to the specific dates to which they refer.

Our research for the ten country project entails legal and policy reviews and empirical work, with input from a range of partners including legal and other practitioners, NGOs and in-country researchers. The aims of the project are to advance understanding of the factors driving high imprisonment levels and to devise strategies to curb the unnecessary resort to custody. The research to date has revealed the range and severity of the health-related impacts of imprisonment. We have set out, through this report, to highlight many of these impacts and to consider the scope for effective health-led interventions in the penal context.

This report does not seek to provide an exhaustive account of health-related vulnerabilities and interventions.<sup>3</sup> Rather, it highlights a number of key issues by drawing on recent academic research and policy reports from across the ten countries and on sources produced by expert bodies such as the World Health Organization. Several of the problems and interventions discussed in this report were the subject of papers presented at an international conference we held in November 2018 at Birkbeck, University of London, *Mapping inequalities in prisoner healthcare worldwide*.<sup>4</sup> The report also features illustrative material about the lived custodial experience as it relates to health, much of it taken from interviews with prisoners and former prisoners which we and our partners have conducted. The latest available statistics on prison populations and overcrowding are drawn from our World Prison Brief database.<sup>5</sup>

It should be understood that we do not approach the topic of prisoner health and healthcare as health experts. At ICPR we conduct policy-oriented research on all aspects of the criminal justice system. Much of this work

<sup>3</sup> Readers wanting to explore prisoner health and healthcare in more depth should review the sources listed under Further Reading (p. 34).

<sup>4</sup> The event was funded by the Wellcome Trust/Birkbeck Institutional Strategic Support Fund. Researchers and practitioners with expertise on prison health in several of the ten countries presented their work across a range of health-related topics. More information can be accessed here: <http://www.prisonstudies.org/news/icpr-holds-international-prisoner-health-conference>

<sup>5</sup> The World Prison Brief (Director, Roy Walmsley), at <http://www.prisonstudies.org/>, is hosted and maintained by the Institute for Criminal Policy Research. The data held on the Brief (which is updated on a monthly basis) are largely derived from governmental or other official sources. Prisons data used in this report were accessed from the database between March and May 2019.

has served to demonstrate the limited value of criminal justice interventions in tackling criminal conduct and the complex social, psychological, economic and other factors which tend to underlie it. We know that people with health problems are greatly over-represented among those who are arrested, prosecuted and imprisoned; and we know that their entry into the criminal justice system frequently worsens health, thereby hindering rehabilitation and increasing the risk of reoffending. It is from this perspective that we approach the topic of prisoner health and healthcare and propose a health-informed approach to penal reform.

## 1.2 Structure of the report

The report has three main chapters. Following this introduction, Chapter 2 considers the health problems with which people **enter prison**. We note that prison populations are disproportionately drawn from the poorest and most marginalised sections of society, within which mental and physical health problems tend to be more prevalent than in the general population. We also note the ease with which certain kinds of mental health conditions can, in themselves, propel individuals into the criminal justice system and ultimately into custody.

Chapter 3 considers some of the ways in which **being in prison** can worsen existing mental and physical health problems and create new ones. This chapter includes discussion of the interlinked problems of poor material conditions, social and psychological stresses, availability of illicit substances, violence and mistreatment among prisoners and staff, and suicide and self-harm. We also look at the scale of overcrowding in prisons around the world and the associated health risks.

In Chapter 4, we highlight the urgent need to address the health-related harms associated with over-use of imprisonment, and propose some ways of doing so. We argue for a two-pronged approach which emphasises, first, reduced use of custody – in general, and for those with significant mental health conditions in particular – and, secondly, improved health provision within prisons.

In preparing this report, we have largely – although not exclusively – used evidence from the ten countries in which we are currently conducting research. The issues addressed, however, have relevance across most of the globe.

**Figure 2: Communal cell, Pollsmoor Maximum Security Prison, Cape Town, South Africa**



© Mikhael Subotzky, courtesy Goodman Gallery

## 2. Health problems with which people enter custody

This chapter gives an overview of some of the main health problems of people entering custody in the ten countries and more generally.

### 2.1 Health problems in populations most affected by imprisonment

Although it is sometimes said that prisons are a microcosm of society at large, in reality the social and economic groupings in society are not represented evenly in prison populations. In fact, it is usually possible to identify the marginalised groups in any society by analysing its prison population (Coyle et al, 2016). Health problems seen in marginalised groups in the community will frequently be mirrored in the health of those in prison.

Prisons are too frequently used as a place to hold people with problematic drug or alcohol use disorders or mental health conditions who (perhaps as a result) cannot find secure work or accommodation and who live in poverty. Prisons often hold disproportionate numbers of people from racial and other minority backgrounds. In some countries, non-nationals and minority ethnic groups may even be the largest grouping in the prison system (as is the case in the Netherlands (Jacobson et al, 2017)).

Physical health problems are also more prevalent among those entering custody, some of whom may have untreated (even undiagnosed) conditions. Infectious disease prevalence is higher among people coming into prison than in general populations. Prisoners show higher prevalence for tuberculosis, hepatitis B, hepatitis C and HIV/AIDS and other infections. They may be more susceptible to infection because their general immunity is lower, due to pre-existing health conditions, poverty, substance use, homelessness and previous incarceration. They may have had little or no access to information and treatment.

This greater prevalence of infectious disease among people entering custody has been noted in higher income countries as well as low- and middle-income ones. For example, it has been highlighted as a particular concern in England and Wales (House of Commons Health and Social Care Select Committee, 2018) and in New South Wales, Australia (Butler & Milner, 2003). People entering custody in Brazil (which now has the world's third largest prisoner population) have recently been found to have unexpectedly high levels of active syphilis (Correa et al, 2017). This study of over 3,000 prisoners in the state of Mato Grosso do Sul also showed that almost 90 per cent of prisoners who tested positive for lifetime or currently active syphilis infection had been unaware of their status.

People entering custody are also at higher risk for some of the main non-communicable diseases including diabetes, cancer, heart disease and respiratory illness. This may be due to prior histories of smoking, alcohol use, poor diet and other factors connected with socio-economic deprivation. Numbers of older people in prison, many with chronic physical health problems or mental health impairments, are rising exponentially in many parts of the world.

### 2.2 Mental health conditions and their criminalisation

A wide range of mental health conditions are associated with criminal conduct or with behaviour that might be perceived as disruptive or threatening. Many people who enter custody (whether on remand or under sentence) do so on account of behaviours that, to some extent, *reflect* an existing mental health condition. In a recent report on Kenya's criminal justice system, a review of police-recorded reasons for arrest showed almost a quarter of all arrests were for offences relating to: 'disturbance or nuisance', 'being drunk and disorderly', 'loitering' and 'using offensive language or conduct'. The apparent condition of individuals taken into police custody included 16 per cent of cases that police recorded as either 'drunk or appearing to be drunk', 'sick', 'mentally disturbed' or 'abnormal' (National Council on the Administration of Justice, 2016).

In much of the world, there is a higher prevalence in prison populations than in general populations of mental health conditions such as depression, personality and anxiety disorders, schizophrenia, bipolar disorder and psychosis (World Health Organization, 2014; Fazel et al, 2016). Major depression and psychotic illnesses are estimated to affect one in seven prisoners (Fazel et al, 2016; Fazel & Seewald, 2012). Women and young people

in prison have a higher prevalence of mental health conditions than adult males (Borril et al, 2003; Chitsabesan & Hughes, 2016). Despite the high level of need, these mental health conditions are frequently underdiagnosed and poorly treated in custody.

Recent international studies have evidenced the higher prevalence of prior traumatic brain injury ('TBI') among criminally involved populations compared with general populations (Williams et al, 2018). TBI symptoms range from mild and temporary to severe. The condition compromises neurological functions that are important for self-regulation and social behaviour and can increase the risks of behavioural and substance use disorders, psychiatric morbidity, self-harm and suicide. TBI has been identified as a potential cause or contributing factor in a range of cognitive and personality disorders and other conditions that have been shown to increase risk of crime, notably violent crime.

People with intellectual disabilities are also over-represented in prison populations, although studies differ as to prevalence (Fazel et al, 2008). These individuals experience significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behaviour, which covers a range of everyday social and practical skills.<sup>6</sup> These characteristics can increase risk of conflict with the law.

Drug and alcohol use disorders are highly prevalent among people entering custody. American research has found that half of the country's prison population met criteria for drug abuse and dependence at the time of their arrest (National Center on Addiction and Substance Abuse at Columbia University, 2010) and that 24 – 36 per cent of the country's heroin addicts pass through prisons each year (Boutwell et al, 2007). It has been estimated that 18 – 30 per cent of men and 10 – 24 per cent of women entering prisons in the United States of America, the United Kingdom and New Zealand meet criteria for alcohol misuse or dependence (Fazel et al, 2006). People entering custody also have high rates of comorbidity for substance misuse and mental illness (for example, Butler et al, 2011).

Research in England has shown that the majority of people entering prison with mental health problems had also experienced one or more of the following (Durcan, 2008):

- trauma and abuse
- limited education
- addiction or problematic substance misuse
- poor general health
- a history of unemployment
- poverty and debt
- homelessness

Challenges like these can easily propel people with underlying mental health problems into (often frequent) contact with the criminal justice system. This may happen because the police are often the first agency called on to intervene when a person experiences severe distress or a mental health crisis, whether or not a crime has been reported. This can escalate rapidly into being charged with an offence and perhaps spending time in custody.

In some countries the police may be under a duty to take action (which can include forcibly removing a person to a place of safety) if they assess someone as having a mental health problem and needing immediate care. This is the case in England and Wales, where police custody can be used as a place of safety if no other

*People come in with a lot of trauma. Living in the middle of it is really extreme. It's difficult. I saw so many people with the hatched scars on their arms, no hairs even grow on their forearms any more...*

*The radiating trauma of people in jail is just hard to describe.*

Male ex-prisoner, England

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<sup>6</sup> From the website of American Association on Intellectual and Developmental Disabilities: <https://aaidd.org/intellectual-disability>



option is available.<sup>7</sup> Thousands are detained every year in police cells under these powers, despite the obvious unsuitability of such environments for people who are mentally or emotionally vulnerable. Although guidance states that this should only happen in exceptional circumstances, the absence of hospital or similar facilities means that in many areas police cells are used more often than hospitals (Bather et al, 2008).

This exemplifies a wider problem. When health services in the community are over-stretched or absent, the police may be the only agency available to respond. In lower income countries there may be more people with severe mental illness in prison than in psychiatric hospitals, because there are fewer resources for community psychiatric care (Fazel et al, 2016).

In some developed countries (including the United States and England and Wales), recent decades have seen significant cuts in mental health service funding. The criminal justice system has to some extent filled the gap left by reduced community services and the closure of state mental hospitals (Grisso, 2008). Prisons have thus become a principal site of assessment and treatment. In some American states, prison administrations are now entitled forcibly to medicate mentally ill prisoners. This has been posited as a further explanation of significant increases in numbers of mentally ill prisoners in those states (Vars & Calambokidis, 2017).

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<sup>7</sup> Under Section 136 of the Mental Health Act 1983 (see footnote 27 below).

## 3. Damage to health caused by imprisonment

In this chapter, we consider some of the ways in which **being in prison** can worsen existing mental and physical health problems and create new ones. This comes about because of poor material conditions, a lack of healthcare, the availability of illicit drugs, social and psychological stresses, violence and mistreatment. As part of this, we look at the scale of overcrowding in prisons around the world. We describe how overcrowded, under-resourced prisons present particular risks to the health of prisoners, prison staff and wider communities.

*There are no words to describe how crowded it is in the cell...*

*It is not enough food and I am hungry all the time. I have lost a lot of weight.*

Male remand prisoner 2, South Africa

(This and all other South African prisoner accounts are taken from affidavit evidence in the case of *Sonke Gender Justice v. the Government of South Africa*, 2016 Western Cape High Court, no. 24087/15 (unreported).)

### 3.1 Conditions of custody

As the previous chapter showed, people entering custody are more likely to have mental and physical health problems and to be at greater risk of ill health than people who do not experience imprisonment. Once in the prison environment, people often experience a worsening of these problems – and may develop new health problems – as a result of the conditions and regime. This can include a general lack of access to treatment and a failure to conduct routine screening or to employ harm reduction methods, often simply because there are insufficient staff to provide these measures.

The typical physical conditions and regime of a prison are not conducive to physical or mental wellbeing either of prisoners or of staff (World Health Organization, 2014). Incarceration in much of the world usually involves:

- reduced access to natural light and fresh air
- poor diet
- limited opportunities for exercise
- reduced access to medical treatment
- the availability of illicit drugs and the presence of drug users
- lack of contact with family members or other support network
- limited activity and interaction with others
- the risk of intimidation or violence
- high levels of boredom, tension and despair.

These aspects of incarceration heighten the risk of disease, violence and mistreatment and can lead to psychological stress, self-harm and even suicide.

#### 3.1.1 Equal rights to health and healthcare

These conditions and their effects on health are in stark contrast to the rights to health and healthcare enshrined in law, including for people in any form of detention. Whatever the nature of their offence, prisoners retain the fundamental rights to which they are entitled as human beings, including those relating to health. International treaties and standards (often reflected in regional and national rules and guidance) make this clear. For example, the International Covenant on Economic, Social and Cultural Rights enshrines every person's equal right to enjoy the 'facilities, goods, services and conditions necessary for the realisation of the highest attainable standards

*Most of the jails do not have specialised doctors such as dentists, gynaecologists, dermatologists, psychiatrists and psychologists to deal with predominant health problems like dental issues, gynaecological issues faced by women inmates, skin allergies or scabies, depression, anxiety or even drug addiction and drug withdrawal. [Medical Officers] deal with almost 80-100 outpatient cases each day, which is a very high number and might mean that proper attention is not given to each patient.*

From *Inside Haryana Prisons*, December 2018, Commonwealth Human Rights Initiative, India

Full inspection report available at:

<http://hslsa.gov.in/sites/default/files/December2018/HaryanaPrisonReport.pdf>

of physical and mental health', without discrimination as to status.<sup>8</sup> Specific international instruments set out what this means in terms of the healthcare provision to be made by prison administrations.<sup>9</sup> Those charged with the medical care of prisoners have a duty to protect their physical and mental health and to afford treatment 'of the same quality and standards as is afforded to those who are not imprisoned or detained'.<sup>10</sup>

These rights apply from the point of first admission to prison, throughout the entire course of the prison term and at the point of preparation for release. Even in times of grave economic difficulty, nothing can relieve the state of its responsibility to provide for the health and healthcare of those whom it has deprived of liberty.

There is a long way to go before these principles become reality. Even when prisons are properly resourced, there will be challenges in ensuring that they are healthy environments. In countries where resources for prisons and wider justice systems have not kept pace with the increasing demands placed on them, or where health services in the community are lacking, these challenges become all the greater.

### 3.1.2 Communicable diseases

It has long been recognised that prisons can be fertile breeding grounds for infectious diseases, particularly tuberculosis, hepatitis B and hepatitis C. There tends to be greater prevalence of infections among people entering custody; and infections are more likely to occur in prison due to the characteristics of the environment (World Health Organization, 2014). Intravenous drug use, unprotected sex, raised levels of violence and lack of sanitation and healthcare are all factors increasing the risk of disease transmission.

Many of the world's prisons have a rapid turnover of people entering custody, particularly remand prisons and low- to medium-security establishments. This presents challenges for limiting infection through screening and treatment. The risks of infection are further compounded when prisons are overcrowded or have limited access to clean water, sanitation, healthcare, vaccination programmes and basic harm prevention tools, as is the case in many of the ten countries under study.

South Africa currently carries the world's highest HIV burden<sup>11</sup> and one of the highest burdens for tuberculosis (World Health Organization, 2016). The country's prison population has more than doubled since 1965 and has been operating well

*I feel really claustrophobic all the time... One toilet is not enough for all of us so we are forced to use a bucket. The smell is disgusting. There is not enough toilet paper, cleaning materials or soap. So the place is disgusting and people get sick all the time.*

Male remand prisoner 1, South Africa

8 Articles 2 and 12, International Covenant on Economic, Social and Cultural Rights. 169 countries have ratified this treaty and are therefore bound by its terms as a matter of international law; 71 signatory countries have yet to ratify (including the USA). In addition, the UN Basic Principles for the Treatment of Prisoners (Resolution 45/111) state: 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.'

9 The Appendix sets out the main regional and international rules and standards.

10 The United Nations 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 or Punishment.

11 UNAIDS website, South Africa country listing, as at March 2019: <http://www.unaids.org/en/regionscountries/countries/southafrica>



above official capacity since at least 1980. The resulting prison overcrowding has created 'hothouse' conditions for the spread of tuberculosis and other infections. Inhumane, degrading and unsafe living conditions have also served to increase the incidence of violence, sexual assault and other behaviours known to heighten the risk of infection. In 2015, the severe health risks presented by overcrowding in one South African prison, Pollsmoor Male Remand Detention Facility, were the subject of a successful constitutional challenge by the NGO Sonke Gender Justice (discussed in Nevin & Keehn, 2018).<sup>12</sup>

Brazil, too, has experienced rapid rises in cases of tuberculosis among its prison population: recent research has concluded that controlling the disease in prisons is critical for reducing its prevalence in the community (Sacchi et al, 2015). Another recent study compared the incidence of tuberculosis among prisoners and in the wider community over several years (Mabud et al, 2019). It found that the prison environment drives the incidence of TB to a greater extent than do characteristics of the prison population itself, despite that population generally having higher risks of infection.

*Our health was bad.  
People died when I  
was there. I got fevers,  
I had TB. I thought I  
would die.*

Male ex-prisoner, Brazil

#### 3.1.3 Non-communicable diseases

*In most jails, prisoners alleged that the same medicines were given for viral fevers, body aches and, at times, even for skin allergies. ... Prisoners suffering from chronic illnesses are the worst hit ... due to the unavailability of specialised medicines in prisons. Jail doctors also cited procurement of medicines as an issue... the state warehouses either had insufficient or incomplete supply of medicines.*

Commonwealth Human Rights Initiative, India (*idem*)

Worldwide, numbers of people suffering from heart disease, diabetes, cancer and respiratory illness are on the rise, particularly in lower income countries and in more marginalised communities. Studies have shown that prisons carry a heavier burden of these diseases than wider communities (for example, Herbert et al, 2012) and that their prevalence in prisons is growing. This is, in part, a reflection of their greater preponderance among socially and economically disadvantaged groups in all societies. A further factor is the rapidly rising number of older people in prison in many countries (in particular in the United States, Australia and England and Wales). This, too, has resulted in more prisoners having one or more of these illnesses.

The prison environment is often characterised by some of the main causes of non-communicable diseases: high levels of smoking; inadequate physical activity; and unhealthy diets. Across both higher and lower income countries, diets in prison are generally too high in carbohydrate and fat content (Herbert et al, 2012). In higher income countries, prison meals are often too high in calorific content or sodium levels, while in lower income countries they sometimes fall short of the recommended daily energy intake.

*They never explained why they did not let us out for exercise. This would make the inmates very frustrated and they would take out their frustration on other inmates by shouting at them or beating them up.*

Male remand prisoner 3, South Africa

#### 3.1.4 Substance misuse in prison

Drug use is endemic among incarcerated populations across much of the world, reflecting the high levels of drug dependence seen in people who are sent to prison. There is also evidence that considerable numbers of people who use drugs in prison acquired the habit in custody (Stöver & Michels, 2010).

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<sup>12</sup> *Sonke Gender Justice v. the Government of South Africa*, Western Cape High Court, no. 24087/15 (unreported). Sonke Gender Justice is an NGO working across South Africa to strengthen government, civil society and citizen capacity to promote gender equality, prevent domestic and sexual violence, and reduce the spread and impact of HIV and AIDS.

*It's awful watching people rot away on heroin in C [Category] prisons, locked up 23 hours a day looking out at an industrial estate and a KFC. Heroin is easy to get in prison, it's everywhere. More people pick up drug habits than get clean in prison. Drugs get in over fences, in all kinds of ways, it's unwavering, people are openly using.*

Male ex-prisoner, England

The consequences of drug use in prison include drug-related deaths as well as suicide attempts, violence, intimidation and self-harm due to drug debts. Drug use tends to be more dangerous in prisons because of the scarcity of drugs themselves and the lack of sterile injecting equipment, which raises the risk of disease transmission.

During the past decade, the use of synthetic cannabis and other novel psychoactive substances (NPS) has become widespread in prisons in some countries.<sup>13</sup> In England and Wales, inspectors have reported that NPS use has led to increased violence, both as a direct result of the drugs' effects and because of violence due to debts (Her Majesty's Inspectorate of Prisons, 2015). European research suggests this is a matter of increasing concern in several other EU countries (European Monitoring Centre for Drugs and Drug Addiction, 2018).

### 3.1.5 Effects of incarceration on mental health

It has long been recognised that psychological harm can result from the loss of liberty, separation from family and community, deprivation of autonomy and material deprivation – all factors that characterise imprisonment.

The often traumatic experience of being taken into custody (for the first time, in particular) can exacerbate pre-existing mental illness and can propel people with mental health vulnerability into violence, substance abuse, self-harm and even suicide. People with existing mental health conditions have been found to be more likely to be involved in violence, victimisation and prison rule infractions (Fazel et al, 2016).

In the context of very long or indeterminate sentences, psychological harm may result from specific features of these, for example, when prisoners have no way of knowing how much longer they will be held once the tariff set by the court has been served (Crewe, 2011). Sentences of this kind often feature ongoing or regular psychological assessments designed to produce evidence to help inform parole boards or courts about whether someone is safe to be released. Prisoners serving such sentences have complained of the unpredictability and obscurity of the assessment and decision-making processes involved. These aspects of the sentence may have adverse effects on mental health and hinder prisoners' efforts to come to terms with their offence and make sense of the sentence they are serving.

*Mentally, the effects of the sentence were to make my memory poor. My mental functioning was very slow after release. I had no confidence, low self-esteem. Technology was impossible for me. Even now I struggle, I have to get help.*

Female ex-prisoner 2, Kenya

*I spent the first month in complete shock and I thought I would wake up and go home. It wasn't real. ... And it hurt - it felt like somebody was ripping my chest open. I saw no future, no point to tomorrow. It was the darkest time of my life.*

'Maria', English prisoner (in Crewe et al, 2017)

### 3.1.6 Suicide and self-harm

Suicide risk is considerably higher in prisoners than in people in the general population of similar age and gender. The relative risk of death by suicide in male prisoners is three to six times greater than that of the general population; and even higher than this for female prisoners (Fazel et al, 2017). Risks of suicide and attempted suicide and of the onset of psychiatric disorders are higher at the point of first entry into custody than later in the prison term: the 'entry shock' phenomenon (Jewkes, 2002: 2).

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<sup>13</sup> Novel psychoactive substances are a range of drugs that have been designed to mimic established illicit drugs such as cocaine, ecstasy and cannabis. Synthetic cannabis has been sold online since at least 2004. It has been reported to have various negative side effects. (Alcohol and Drug Foundation, Australia. <https://adf.org.au/drug-facts/ne2w-psychoactive-substances/>)

A recent international comparative study examined prison suicide rates in 24 higher income countries,<sup>14</sup> including four of those featured in our ten country study – England & Wales, Netherlands, Australia and the United States of America (Fazel et al, 2017). This found no evidence to link high suicide rates with high incarceration rates. In fact, the reverse was indicated, with the Nordic countries and the Netherlands having some of the highest documented rates of prisoner suicide, yet the world's lowest incarceration rates. By contrast, rates of prisoner suicide in America and Australia were considerably lower, despite these countries' higher incarceration rates. Nor was the higher number of prisoner suicides a reflection of more suicide in the countries' general populations. Instead, individual prisoner-level factors were considered the most likely explanation for high suicide rates. These factors include the fact that prisoners in countries with *lower* incarceration rates are statistically more likely to have committed serious violent crimes or have a mental illness, both of which are associated with increased suicide risk (see also Fazel et al, 2008).

There is also evidence that recently released prisoners are at even greater risk of suicide than serving prisoners, particularly in the year after release (with this risk being higher still in the first four weeks) (Pratt et al, 2006 and Spittal et al, 2014). In a large-scale Swedish study, links were found between post-release suicide and previous substance use disorder, relapse into drug use, and homelessness (Haglund et al, 2014).

*You have no reason to hope for a brighter future, you're done, you're oppressed, every ounce of you is taken. So many women commit suicide as soon as they're released.*

Female ex-prisoner 1, Kenya

#### 3.1.7 Vulnerable sub-groups of prisoners

Being in prison carries greater health risks for some people as a result of their specific characteristics or vulnerabilities or because of the prison's inability to meet their health needs. When conditions are overcrowded and prisons are under-resourced, the potential impact on their health may be even more serious. Reduced levels of staff monitoring and intervention together with raised levels of tension and violence may leave them more susceptible to abuse and they may find it more difficult to access treatment and support.

#### Female prisoners

Women in prison have frequently suffered physical, mental or sexual abuse and often have untreated health problems (Moloney et al, 2009). Rates of mental illness are higher in female prisoners than male (Binswanger et al, 2010). Women are likely to have histories of substance misuse and childcare issues and are at significantly

*I'd been abused before, and prison reawakened my past feelings of fear. I walked into the prison and felt just fear.*

Female ex-prisoner 2, Kenya

higher risk of self-harm and suicide in prison (Corston, 2007). Many of the vulnerabilities documented in female prison populations mean that imprisonment does disproportionate and lasting harm, prompting calls for greater community provision and for the abolition of female imprisonment (for example Coles et al, 2018).

Female prisoners constitute a minority of incarcerated populations:<sup>15</sup> around 7 per cent in Brazil, 10 per cent in the United States, 8 per cent in Australia, 13 per cent in Thailand, 4 per cent in India, 3 per cent in African countries and 5 per cent in Western Europe (Walmsley, 2017). As most prison systems have been designed to accommodate male prisoners, they are

rarely equipped to meet women's specific needs. Health services for women in prison are sometimes minimal. Standards of prison healthcare often fall below those of women's health services in the community (World Health Organization, 2011).

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<sup>14</sup> The data included suicides in pre-trial/remand detention as well as among sentenced populations: disaggregated prisoner suicide data were not available.

<sup>15</sup> Albeit a rapidly growing minority: see section 4.2.1 below. The percentages shown here have been rounded to the nearest whole number.

*When we gave birth, the diet for us and the babies was bad, there was no special diet for us or the kids, and this had a bad effect on our health.*

Female ex-prisoner 4, Kenya

Even fewer prisons are equipped to meet the specific needs of women who are pregnant or have their babies in prison with them (Macmadu et al, 2017). Imprisoned women who are pregnant are a high-risk obstetric group and are more likely to have a medical problem that could affect the pregnancy outcome, yet are less likely to receive adequate antenatal care (Knight et al, 2005).

### **Lesbian, gay, bisexual and transgender (LGBT) prisoners**

LGBT people face heightened risks of violence, discrimination and abuse, with severe consequences for both physical and mental health. Sexually transmitted infections are a further health concern since LGBT prisoners are at higher risk of rape and assault in some countries (including when prison staff wrongly assume that sexual conduct is consensual (Tarzwell, 2006)).

Transgender women are at high risk of violence in custody and experience greater health disparity (McCauley & Brinkley-Rubinstein, 2017). Custody for transgender people is associated with reduced access to healthcare and persistent mental and physical health problems – often reflecting the social marginalisation they experienced prior to imprisonment. Transgender prisoners have specific health needs relating to ensuring (continued) access to hormone therapy and other interventions required for transitioning. Access to suitably qualified healthcare practitioners with an understanding of these needs is important but often lacking in prison settings.

Research on the experience of lesbian, gay and bisexual prisoners has mainly focused on the normalisation of homophobia and suppression of gay male sexuality in hyper-masculine prison cultures (for example Jewkes, 2002). The proscription of sexual relationships in prison and the failure to supply condoms and adopt other harm reduction approaches can heighten the risks of disease transmission through same-sex relationships.

### **Young prisoners**

Children and young people in custody are likely to have experienced multiple levels of disadvantage and to have deep-rooted and complex needs (Jacobson et al, 2010). The physical health of young people in custody tends to be worse than that of their peers in the general population. They are also more likely than other young people to have mental health problems, intellectual disabilities and substance use disorders. In a custodial setting, the irritable mood that often accompanies depressive disorders in younger people can incite aggressive responses in others, or result in self-harming behaviour. In America, an estimated 50 to 75 per cent of youths in contact with the juvenile justice system meet criteria for a mental health disorder; and up to 80 per cent of incarcerated juveniles may have at least one diagnosable mental health disorder (Grisso, 2008).

### **Older prisoners**

Prisoners tend to experience age-related health problems at a rate equivalent to people a decade older in the community. Accordingly, 50 year-old prisoners show the same signs of age-related infirmity and cognitive decline as 60 year-olds in the general population (Baidawi et al, 2011). This could result from deprivation, stress and the numerous health disadvantages associated with imprisonment. Many of the mental and physical health problems faced by older people are exacerbated by factors typical of prison settings, including smoke-filled environments, lack of exercise, poor diets, higher levels of victimisation, and lack of social interaction and mental stimulation. Most prisons lack any form of geriatric healthcare service and do not cater for the needs of older prisoners with health problems, rendering them all the more vulnerable in custody (Potter et al, 2007).

*Old and infirm patients were also kept in jail hospitals. In Central Jail, Hisar II one of the admitted prisoners was 114 years old.*

Commonwealth Human Rights Initiative, India (*idem*)

Older prisoners typically suffer from chronic (often multiple) physical health problems. They are susceptible to illnesses such as heart disease, diabetes, hypertension, cancer, hearing and vision impairment and a range of

physical disabilities including dental problems and eating difficulties (World Health Organization, 2014). Older prisoners' mental health can be affected by conditions such as dementia, Alzheimer's disease, memory loss, Parkinson's disease, depression and fear of dying – particularly dying in prison.

Some elderly people are imprisoned with a pre-existing (possibly undiagnosed) cognitive impairment or psychiatric disorder. These conditions can be accelerated or worsened by the physical and social conditions in custody. Prisoners are more prone to developing dementia than the general population because of the risk factors associated with incarceration (Christodolou, 2012). These include inactivity, poor nutrition, smoking and a lack of social interaction. In addition, mental health conditions common among prisoners and associated with dementia (such as depression, traumatic brain injury, and attention deficit hyperactivity disorder) might also contribute to higher rates of dementia among prisoners.

On reception prisoners are not routinely screened for cognitive impairment and staff often fail to identify the signs. The prison's mental health services may be focused on other inmates with more challenging behaviour. Cognitive deficiencies can be harder to detect in prison than when people succumb to them in the community, because prisoners do not usually have to perform the same number of daily tasks as older people living independently (Williams et al, 2012).

#### **Prisoners from racial and ethnic minority backgrounds and foreign nationals**

Prisoners from minority groups may have special healthcare needs as a result of prior socioeconomic marginalisation (World Health Organization, 2014). They may have received inadequate medical care prior to imprisonment. They may also be at a higher risk of some conditions (for example, Indigenous Australians have higher rates of physical and mental ill health than non-Indigenous Australians (Jorm et al, 2012)). Foreign national prisoners have been found to suffer higher rates of both physical and mental health disorders and to find it more difficult to access healthcare in custody (Till et al, 2019). Prisoners in either group can find it difficult to access treatment in custody due to lack of translated or accessible materials and other support. Separation from family and community can also take a heavier toll on prisoners in these groups (World Health Organization, 2014).

#### **Prisoners with physical disabilities**

This growing category of prisoners generally has greater healthcare and rehabilitation needs. An absence of suitably qualified staff and the failure to make necessary adaptations to the physical environment can present risks to their health and wellbeing. Prisoners with sensory disabilities often become isolated in the prison environment, causing difficulties in accessing care and treatment and potentially leading to mental health problems (World Health Organization, 2014).

#### **Prisoners with intellectual disabilities**

People with intellectual disabilities are at significantly higher risk of experiencing fear and anxiety in the prison environment and of being subjected to bullying, segregation, or use of restraint or control techniques (Talbot, 2008). They may incur unwarranted disciplinary sanctions for conduct related to poor judgment or difficulty in complying with rules and instructions. Research has found that many people with these difficulties 'are left to fend for themselves in a shadowy world of not quite knowing what is going on around them or what is expected of them' (*idem*: 75).

#### **Prisoners with mental health problems**

Prisoners with mental health problems are at higher risk of self-harm, suicide, substance misuse, sexual victimisation, and of experiencing and committing violence in custody (Yoon, 2017; World Health Organization 2014). They are also more likely to be segregated or placed in solitary confinement, the adverse health consequences of which have been found to be particularly severe for prisoners with mental health problems (for example Grassian, 2006).



## 3.2 Overcrowding

Prison overcrowding is a significant contributor to the damage that imprisonment can cause to the health of both prisoners and prison staff. It is a cause of severe psychological stress, which exacerbates mental health conditions. It is a major factor in the spread of infectious disease and the worsening of chronic conditions. Overcrowding also makes rehabilitation all but impossible, presenting a heightened risk of re-offending after release.

*The overcrowding was very bad, there were 60 men in a 20 person cell. There were a lot of addicts... that made it more stressful. The worst thing was the hunger. If family members brought in food for us, we had to share it round.*

Male ex-prisoner, Brazil

*The worst part in prison was the night time, when night comes there is no sleep, really there is no night time, just a different life that starts, a lot of fighting and noise, crying. It's hell. The lights stay on and the guards are all over the prisoners. You go to bed in fear as you never know what will happen, who will beat you up. I still can't sleep at night.*

Female ex-prisoner 1, Kenya

Overcrowded prisons mean cramped and unhygienic accommodation; a constant lack of privacy (even when using the toilet); reduced out-of-cell activities (due to pressure on staff and less access to facilities); limited access to treatment and medicine due to overburdened healthcare services; poor conditions for sleeping; unsafe conditions due to weakened prison management; and increased tension and despair among prisoners, which can result in violence, substance misuse, self-harm and, in extreme cases, suicide.

The Care Quality Commission in England has recently confirmed that:

'Overcrowding and lack of personal space are acknowledged stress factors for both prisoners and staff that impact on the delivery of an effective health service. The significant impact on prisoners' general health and wellbeing includes increased risks associated with privacy/confidentiality, communicable diseases, sleep hygiene and anxiety/depression.'<sup>16</sup>

### 3.2.1 What is 'overcrowding'?

The starting point for determining whether a country's prison system suffers from overcrowding is to look at the official capacity of the country's prison estate – as stated by its relevant prisons authority – and the actual occupancy level shown by that country's total prison population.<sup>17</sup> If the official capacity for country X is stated to be 50,000 but the occupancy level is 60,000, this indicates that country X is operating at 120 per cent of its official capacity – or, it is overcrowded by 20 per cent.

The occupancy rate alone cannot be taken as a definitive indicator of the extent of overcrowding or the impact it may have on health, for several reasons. First, there are no fixed rules on how much physical space should be allowed per prisoner. In Europe, the Committee for the Prevention of Torture has issued standards on living space per prisoner.<sup>18</sup> These specify a basic minimum space of 6m<sup>2</sup> for a single-occupancy cell, excluding the sanitary facility; and 4m<sup>2</sup> per prisoner sharing a multiple-occupancy cell, excluding a fully-partitioned sanitary facility, at least 2m between the walls of the cell and at least 2.5m between the floor and the ceiling of the cell. For multiple-occupancy cells for up to four inmates, the standards recommend that 4m<sup>2</sup>, per additional inmate, should be added to the minimum living space of 6m<sup>2</sup>.

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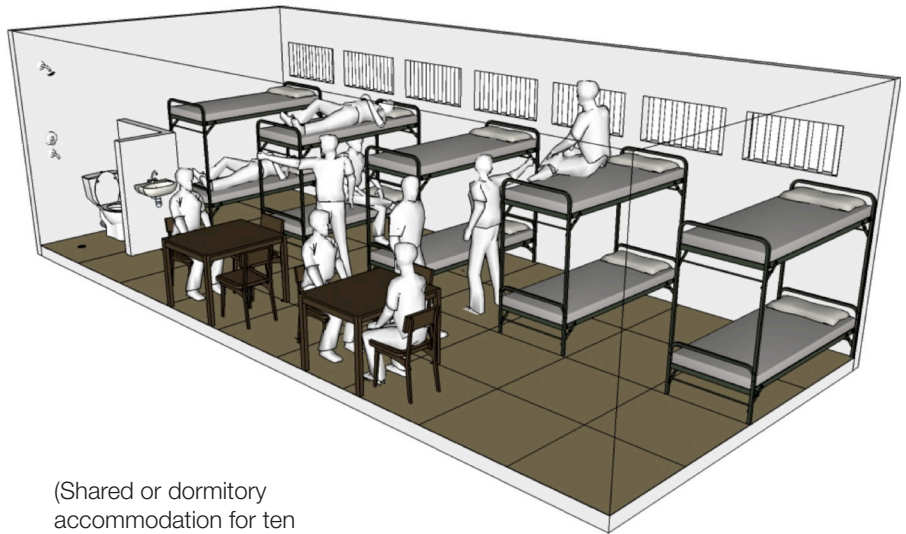
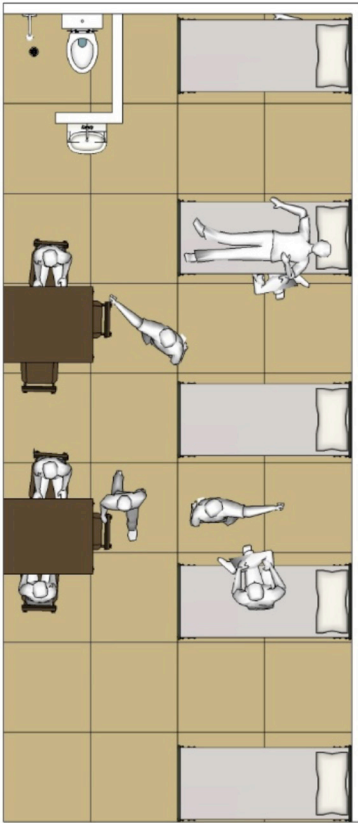
16 Written evidence to House of Commons Health and Social Care Select Committee (2018): Prison Healthcare inquiry. Available at <https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/inquiries/parliament-2017/prison-healthcare-inquiry-17-19/publications/>

17 ICPR's World Prison Brief website provides information on the occupancy rates of most countries in the world. The information is based on the most recent official capacity figure published by a country, and the national prison population total as at that date.

18 CPT Standards on living space per prisoner in prison establishments, December 2015

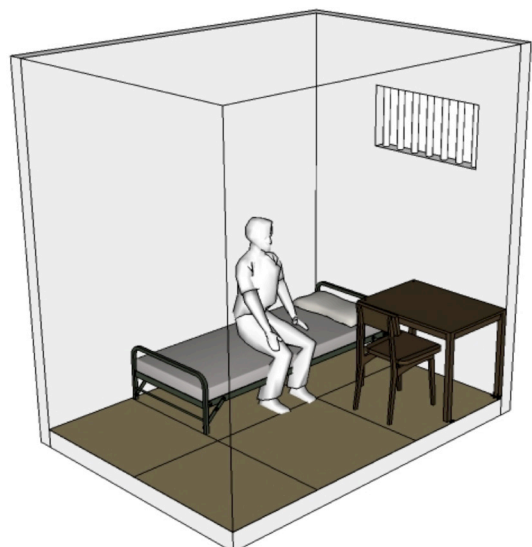
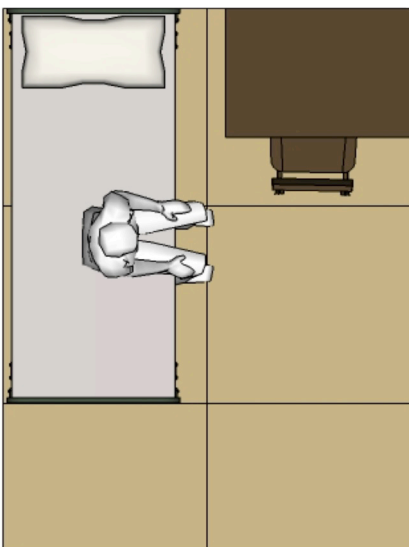
In the absence of any universal standards for single or multiple occupancy cells, the International Committee of the Red Cross (ICRC) has developed recommended minimum space specifications based on its own experience of visiting prisons around the world (ICRC, 2012). These are reproduced in Figures 3 and 4 below.

**Figure 3: Multiple occupancy cell: © ICRC**



(Shared or dormitory accommodation for ten prisoners: 3.4 m<sup>2</sup> per person, including where bunk beds are used. Total area: 34 m<sup>2</sup>. Includes toilet facilities. (ICRC, 2012))

**Figure 4: Single occupancy cell: © ICRC**



(Single cell accommodation: 5.4 m<sup>2</sup> per person. Excludes toilet facilities (ICRC, 2012))

Many countries base their official capacity on cell accommodation that provides so little space per prisoner that anything close to 100 per cent occupancy rates in such a country would amount to serious overcrowding. It is also important to recognise that occupancy levels fluctuate over a given period, with many more people entering a country's prison system in the course of a year than the 'stock' number represented by national prison statistics and shown on the World Prison Brief. Consequently, there may be far greater numbers in custody at certain points over a given year than there are on the date to which the stock figure refers. Prison stock data can also be many years behind the current year because some countries are slow to publish prison statistics. Overcrowding can also exist in some prisons of a country even when its overall occupancy rate is below 100 per cent.

*At that time I remember that there were so many people sent to prison. It was extremely crowded to the point that we needed to snatch or take everything from each other. It was like a competition to survive, you know? The sleeping space, the food, everything...'*

'Inmate H', Thailand

*It was very overcrowded. If an inmate went to the toilet, he could not come back to his place, so he must stay and sleep near the toilet. There were some occasions that I had to sleep sitting on the floor because I did not have any space to lay my body down...'*

'Inmate J', Thailand

*(Prisoner interview extracts drawn from Netrabukkana, 2016)*

The severity of prison overcrowding and its potential health impact should not be assessed purely by reference to the physical space available to each prisoner. The amount of time that prisoners are locked in their cells and whether cells are shared with others will also affect the impact of overcrowding on health.

Being locked for up to 23 hours a day in a cell intended for one person but shared by two or three requires cell-mates to eat, and to use the toilet, in the same small space. Such conditions may well be worse for prisoners' health than sleeping in a crowded communal cell at night and then spending the day outside the cell working and interacting with others. On the other hand, if night-time conditions in a dormitory cell make sleeping impossible because of noise, bright lights, or lack of personal space, the health impact of overcrowding will be worse.

It follows that the mental and physical health impacts of overcrowding depend not only on the physical living space provided in the cell, but also on factors such as: time locked up in the cell; number of people sharing the cell; sleeping conditions; opportunities to exercise, work and interact with others; access to light and fresh air; standards of sanitation; access to drinking water; quality and sufficiency of diet; and availability of medical treatment and healthcare. These factors are crucial in preventing disease and limiting risks of disease transmission, but are often compromised when prisons are overcrowded and under-resourced. The health and wellbeing of prisoners and staff are at risk as soon as resources come under pressure, as they do in any prison operating above official capacity.<sup>19</sup>

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<sup>19</sup> See affidavit of expert witness Ms Arina Smit dated 7 December 2015, in the case of *Sonke Gender Justice v Republic of South Africa and another*, High Court of South Africa, Western Cape Division, Cape Town, Case No 24087/35 (extract quoted on p. 23 of this report).



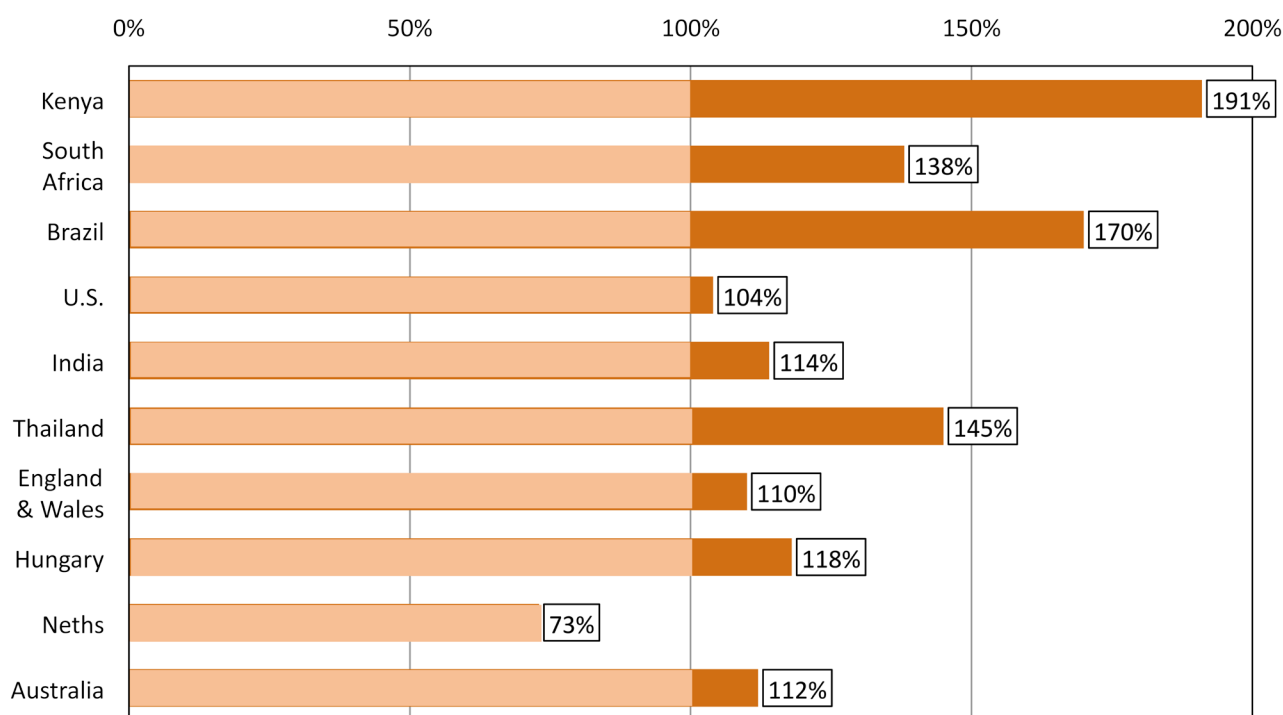
### 3.2.2 The extent of prison overcrowding in the ten countries and worldwide

ICPR’s World Prison Brief database holds prison population data for almost every country in the world, with figures available for 223 jurisdictions. The Brief also provides information on the extent to which the world’s prison systems are overcrowded, based on each system’s official capacity.<sup>20</sup> As shown in Figure 5 below, all but one of the countries under study in the ten country project are currently running over-capacity.

*In some cells the moving space is so small that some of the inmates have to sit on the toilet seat while eating.*

Hungarian Helsinki Committee, Communication in cases of *Szél v. Hungary and István Gábor Kovács v. Hungary* (judgments of the European Court of Human Rights, Strasbourg, October 2014)

**Figure 5: Prison overcrowding levels in the ten countries\***



\*Figures based on most recent national official capacity data as of May 2019 (all as shown on World Prison Brief database). Figures vary by jurisdiction as to the specific dates to which they refer.

World Prison Brief data indicate that, of the 205 countries worldwide for which official prison capacity numbers are available, 60 per cent have occupancy rates above 100 per cent. This includes 24 countries with occupancy rates above 200 per cent.

By continent, overcrowding levels are worst in Africa, where 87 per cent of all states are operating above official capacity (and 13 have occupancy rates above 200 per cent). In the Americas, 68 per cent of countries are operating above official capacity (of which seven have occupancy rates above 200 per cent). In Asia, 66 per cent of countries are operating above official capacity (and 4 countries have occupancy rates above 200 per cent). In Europe and Oceania many countries are operating above official capacity but none has occupancy levels as high

20 The countries for which official capacity numbers are not available are: Egypt; Central African Republic; Republic of the Congo; Democratic Republic of Congo; Equatorial Guinea; Gabon; South Sudan; Eritrea; Ethiopia; Somalia; Cuba; Oman; Qatar; Saudi Arabia; Yemen; Bhutan; Laos; Vietnam; China; North Korea; and Tuvalu.

as 200 per cent. Hungary has seen some of Europe's worst prison overcrowding in recent years and currently operates at 118 per cent of official capacity. In Australia, available data indicate that prisons are operating at 112 per cent of official capacity.<sup>21</sup>

**Figure 6: Interior of cell at the Bács-Kiskun County Penitentiary Institution, Hungary**



(Photograph courtesy of  
Hungarian Helsinki  
Committee prison monitors)

In summary, we can conclude that **well over 60 per cent** of countries worldwide have overcrowded prisons. The public health risks this presents are of great concern. Many of these countries have large prison populations, with potentially hundreds of thousands of individuals passing through their prisons each year. Many also have relatively low standards of community public health provision and carry heavier burdens of transmissible diseases including HIV/AIDS, hepatitis and tuberculosis.

Prison overcrowding is usually a consequence of over-use of custody (including at the pre-trial stage), combined with insufficient investment in prison buildings and other resources. As we explain in the next chapter, reduced overcrowding is a precondition for better prisoner health.

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<sup>21</sup> Australia has not published a national official capacity figure since 2013: this was 31,335. We have sourced more recent state/territory capacity figures, to arrive at a current national capacity figure of 36,730, as reflected on the World Prison Brief database.

## 4. Developing a health-informed approach to penal reform

Chapters 2 and 3 have demonstrated that prison populations bear a far greater burden of mental and physical health problems than general populations. This is partly due to pre-existing health problems among people who enter custody and partly also to factors in the prison environment. We have noted that existing health problems can be exacerbated by imprisonment; and that new health problems can come about as a result of poor conditions and lack of treatment, especially in countries where prisons are overcrowded.

In this final chapter, we first address some of the implications of these unequal burdens and elevated risks of poor health in prison populations. We then set out the case for a health-informed approach to penal reform. In doing so, we highlight a selection of advances in research and practice that could contribute significantly to higher standards of prisoner health and healthcare. We present interventions capable of addressing mental or physical health risks and needs at different points along the custody process, from first contact with the police, through sentencing, to preparation for release from custody. The advances we discuss have been drawn from among the countries featured in the ten country project, but could be adapted for use in other systems.

### 4.1 Imprisonment and the associated health risks: the implications

A sentence of imprisonment is a sentence of deprivation of *liberty*, not of damage to health. There is a wealth of evidence to suggest that governments in many countries are failing in their duty to protect prisoners' physical and mental health and provide adequate health treatment. Throughout this report, we have presented accounts from people who have first-hand experience of the damage custody can do to prisoners' health. These accounts describe overcrowded and under-resourced prisons struggling to provide basic sanitation, drinking water, food, medication, exercise, or sufficient living and sleeping space. They reveal how prisoners are often unable to access the care and treatment they need, even for life-threatening conditions like diabetes, tuberculosis and HIV.

Being imprisoned in such conditions would take a heavy toll on the health of anyone; but when a person's health is already poor on entry into custody, as is so frequently the case in both developed and less developed countries, the toll is even heavier. The implications are serious, from several distinct perspectives.

*It was very dirty, our children regularly got sick, with diarrhoea, skin diseases, cholera, they had colds all the time.*

Female ex-prisoner 1, Kenya

From an **ethical and human rights perspective**, it is scandalous that people in poor physical or mental health are being detained in inhumane, degrading and unsafe conditions without adequate medical treatment. The consequences are disease, violence, intimidation, self-harm and suicide, representing gross infringements of the human rights of prisoners and prison staff. If the state cannot offer decent and humane living conditions in its prisons, or provide healthcare equivalent to that provided in the community, incarceration is open to challenge on human rights grounds. It was a ruling to this effect

by the United States Supreme Court that ultimately forced California to enact reforms to bring an end to decades of mass incarceration (as explained in Simon, 2014).<sup>22</sup> The Court held that California was infringing prisoners' Eighth Amendment right not to suffer cruel and unusual punishment, because the state's criminal justice and health policies were effectively causing thousands of prisoners to be exposed to extreme medical and mental health suffering. The ruling made history in its declaration of dignity as a constitutional value as it relates to prisoners and may well stand as the high-water mark of American jurisprudential protection for prisoners' rights.

From a **public health perspective**, there are serious risks in holding people in insanitary and overcrowded prisons without access to screening, treatment or basic harm reduction measures. The risks of communicable diseases spreading quickly

*My body feels so stiff. On average we probably get out of the cell about an hour a week...I do not get given my [TB] medication daily as it was prescribed. This makes recovery difficult, particularly since there is little air in the cells and lots of second hand smoke...*

*There are lots of sick people inside the cell. We all have bites from lice.*

Male remand prisoner 4, South Africa

<sup>22</sup> *Brown v Plata* 563 US 493 (2011)

among prisoners and staff and, from them, to their families and wider communities, are one aspect of this. Another is the heightened risk presented by the release of prisoners suffering from mental health conditions that have arisen (or worsened) as a result of a harmful custodial environment.

From a **criminal justice perspective**, when imprisonment leaves people in worse health than when they entered custody, the prison system fails to tackle crime other than through the brute fact of incapacitation. Most penal systems, including several of those in our ten country project, rank the rehabilitation of offenders highly among the purposes of imprisonment: in some countries, such as the Netherlands, it is expressly prioritised.<sup>23</sup> An essential pre-condition of rehabilitation is an environment that guarantees adequate care and protection for the health and wellbeing of prisoners and staff alike.

In reality, effective healthcare, rehabilitation and resettlement services will be hard to find in the under-resourced or over-crowded prison. When people leave prison without having accessed the support they need, or in poor health, their prospects of finding and keeping a job and a home and of avoiding the misuse of drugs and alcohol will be reduced. This in turn can increase the risk of reoffending and returning to prison, perhaps in worse health – the ‘revolving door’.

Tackling these challenges requires a health-informed approach to penal reform that has two major components. The first is reducing numbers in custody. The second is improving conditions and health provision in prisons. We deal with each in turn below.

*So many are left by their husbands during time in prison – then their families won't take them back. Women are expected to be with their husband till they die. So once you've been criminalised you're beyond help and society doesn't care. You end up on the street or back in prison.*

Female ex-prisoner 1, Kenya

## 4.2 Reducing numbers in custody

We approach this in two stages. First, we briefly discuss the need to reduce the size of prison populations overall (including pre-trial/remand and sentenced prisoners); we then focus on options for reducing numbers of prisoners with mental health conditions.

### 4.2.1 Reducing overall numbers in custody

In 2000 the world's prison population was around 8.7 million: in less than two decades, it has increased to its present level of at least 11 million (Walmsley, 2018). Many countries have seen particularly rapid and unsustainable rises in their prisoner populations in just a few decades. America's total prison population more than quadrupled between 1980 and its peak in 2008. In Brazil, prisoner numbers increased twenty-fold from around 30,000 in 1973 to nearly 720,000 today.<sup>24</sup> See Figure 7 for the percentage change in total prisoner numbers in each of the ten countries.

The growth of some prison population groups is all the more concerning in view of their specific health needs and vulnerabilities. The global female prison population has risen far more steeply than the male, having grown by more than 50 per cent since 2000 (whereas male prisoner numbers grew by around 20 per cent in the same period) (Walmsley, 2017). Numbers of women prisoners have risen in all five continents, but by larger margins in the Americas, Asia and Oceania than in Europe and Africa. There have also been significant increases in the numbers of foreign and ethnic minority prisoners over recent decades, particularly in western European countries.<sup>25</sup>

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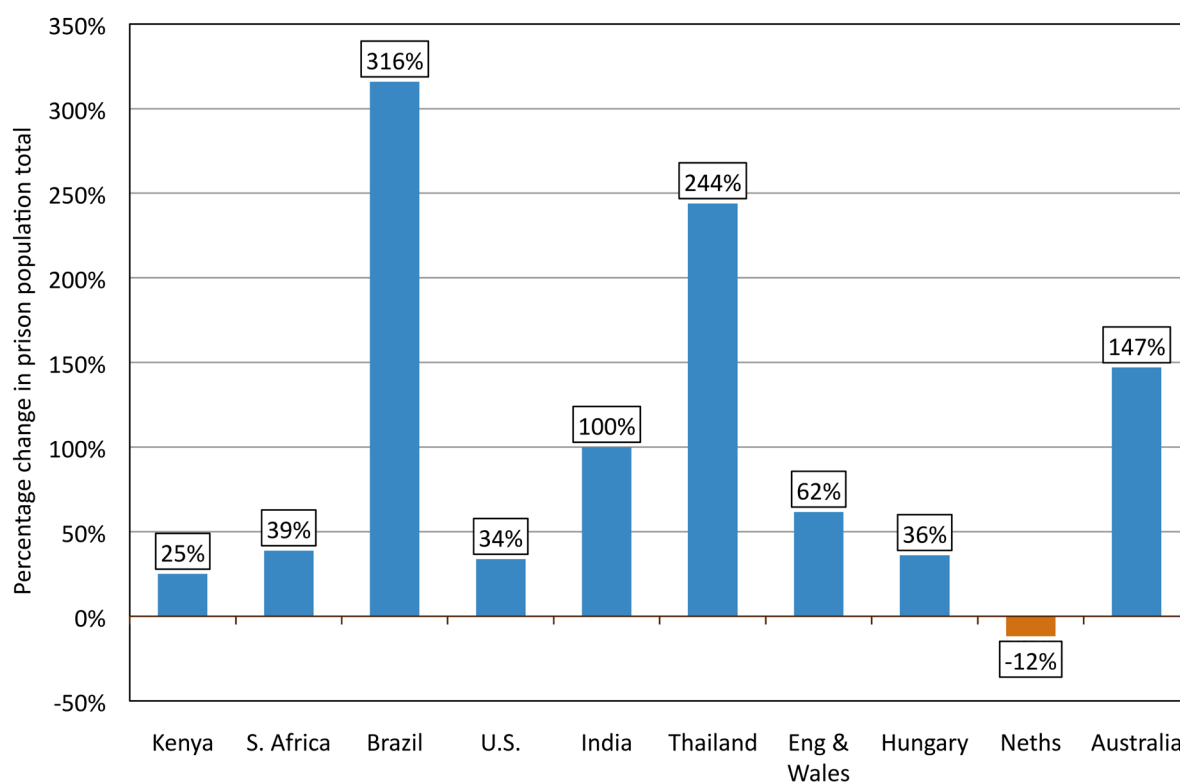
23 Netherlands Penitentiary Principles Act 1998 (*Penitentiare beginselenwet*)

24 For a more detailed account of each of the ten countries' recent imprisonment trends within a global context, see Jacobson et al, 2017, [http://www.prisonstudies.org/sites/default/files/resources/downloads/global\\_imprisonment\\_web2c.pdf](http://www.prisonstudies.org/sites/default/files/resources/downloads/global_imprisonment_web2c.pdf).

25 See for example Aebi et al, 2018.

The proportion of older people in custody has also been rising steadily. Between 1990 and 2009 the total prison population of America doubled, but the number of prisoners aged 55 or older increased by over 300 per cent (Williams et al, 2012). There are several distinct reasons for this growth. Many countries have increased their use of life or other indeterminate sentences (Jacobson et al, 2017); and prisoners serving these sentences often spend many years in prison, well into their old age and, in some cases, until their death. Other reasons include longer custodial sentences, mandatory sentencing laws and a greater preponderance of older people being sentenced to custody for serious offences (notably, when ‘historic’ crimes are prosecuted).

**Figure 7: Percentage change in prison population totals since 1995\***



\* Percentage change in prison population total since 1995 for all countries (Kenya 1996) to most recent date for which figures are available. Data are drawn from World Prison Brief database as of May 2019.

To curb prison population growth, reform is needed at many levels, both in the realm of criminal law and policy and more broadly, reflecting the many interwoven factors driving this growth. A thorough description of the options for reform is beyond the scope of this report,<sup>26</sup> but key measures include:

- The use of pre-trial detention should be reduced so that it is a last resort and is used for the briefest possible period. Alternatives to pre-trial imprisonment should be properly funded and organised. Investment in court systems and judicial capacity should be made to reduce case backlogs and ensure regular detention reviews.
- The use of custodial sentences for less serious and non-violent offending should be a last resort. Community alternatives (including rehabilitative and treatment orders) should be available to replace these.

<sup>26</sup> The Council of Europe addressed the issue of overcrowding in a White Paper published in 2016 (Council of Europe, 2016). The White Paper points to the inadequacy of state responses based solely on increasing prison capacity and other short-term measures. It calls on governments to address instead the root causes of overcrowding, by promoting better use of alternatives to custody, decriminalising some offences, and providing for more rigorous prison monitoring.

- The recent growth in the length of prison sentences (including the greater use of life and other indeterminate sentences) should be reversed, so that custodial terms are of fixed duration and proportionate length, with a focus on rehabilitation and preparation for release.

#### *4.2.2 Reducing numbers of people with mental health conditions in custody*

The prison setting will rarely be a positive one for mental health treatment. A range of measures and options can be pursued to divert from prison (and perhaps from prosecution) people who, on account of their mental health conditions, should not be in custody at all. These include measures to divert people away from the criminal justice system at the point of their first contact with police following an arrest or a report of unusual or disturbing conduct.

If a person with mental health problems is prosecuted and convicted, treatment orders and similar measures can be used by courts at the sentencing stage, with input from social workers, psychologists, probation officers and other experts. It should also be possible to transfer from custody into more suitable accommodation people whose mental health has significantly deteriorated in prison, for example, prisoners with severe dementia or a terminal illness.

We outline below some specific interventions capable of reducing numbers of people with mental health problems in custody, which could be adapted for use in other similar jurisdictions. These approaches require a reasonable level of community-based provision and decent, humane alternatives to custodial settings. In much of the world, community mental health services, psychiatric hospitals and residential units suited to the needs of mentally ill or otherwise vulnerable people are scarce or non-existent. Where this is the case, the first stage of any reform process must be an assessment of existing alternatives and of the available resources to build alternative capacity and health provision in the community. The measures outlined below also require effective systems for information-sharing and collaboration between the police, probation and court services, on the one hand and health and social services, on the other. Putting these systems in place will be a necessary first step to reform in some countries.

#### **Diversion schemes**

Lord Bradley's review of people with mental health problems in the criminal justice system of England and Wales reported in April 2009 (Bradley, 2009). Many of its recommendations have been instrumental in changing policy and practice. The review highlighted the importance of diverting people with mental health needs away from prosecution and prison into treatment and care. One intervention flowing from this has been the system of 'liaison and diversion'. The essential elements are:

- identifying people coming into contact with the justice system with mental health problems, intellectual or learning disabilities, substance misuse or other vulnerabilities
- assessing the identified individuals and referring them to an appropriate treatment or support service
- sharing information (with the individual's consent) with criminal justice agencies and the judiciary, so that informed and timely decisions can be made about case management and sentencing.

Clearly the success of such schemes depends on the availability of community support and treatment options. A chronic shortfall in funding for mental health services has been identified as a potential limitation on its future effectiveness in England and Wales.

#### **'Street triage' systems**

In recognition of the high degree of involvement between police and individuals who may have mental health problems, the street triage system was introduced in parts of England in 2013. It involves dedicated mental health professionals working in teams with police officers, listening to calls for assistance, attending scenes that



may have a mental health element and offering tailored interventions to ensure that individuals receive the most appropriate care, whether or not they are already known to mental health services. The system has reportedly led to fewer detentions by police under mental health legislation<sup>27</sup> and has fostered improved collaboration between police and mental health services. It has also produced better understanding of service users' needs and helped to de-stigmatise mental health problems.<sup>28</sup>

### Sentencing and treatment orders

Sentencing decisions should be individualised to take account of any mental health issues and the possible effects of a custodial sentence. This is not a common feature of sentencing systems, but some recent advances are notable. In Australia, specific sentencing principles<sup>29</sup> set out how mental health problems should be taken into account in the sentencing process. These principles guide the court to consider whether imprisonment would weigh too heavily on the offender or damage his or her mental health. In England and Wales, any sentencing decision relating to a child or young person should take account of the person's welfare. As part of this, the court is now required to 'ensure that it is alert to any experiences of brain injury or traumatic life experience (including exposure to drug and alcohol abuse) and the developmental impact this may have had'.<sup>30</sup>

*I was depressed and angry during all my prison sentences. I felt isolated and abandoned – I had no visits, I had no family.*

Female ex-prisoner, Brazil

Some jurisdictions make provision for courts to pass sentences or make orders requiring offenders to undertake treatment in the community to help them with mental health problems or alcohol or substance use issues. These orders generally embody a multi-agency approach with information and expertise being shared as necessary among health and justice professionals. The aim is usually to identify and meet the needs of people convicted of an offence who have a mental illness or substance/alcohol use disorder and to limit their re-offending risk, if possible without recourse to custody.

In England, the Mental Health Treatment Requirement attached to a Community Order is intended for the sentencing of offenders convicted of an offence falling below the threshold for a custodial sentence, where their mental health problem does not require secure in-patient treatment. It is essentially an agreement between the offender, the probation officer and the clinician (usually a psychiatrist). The offender must agree to receive regular mental health treatment as part of the requirement (National Offender Management Service, 2014).

A Community Order imposing a Drug Treatment Requirement is also available to courts in England, when the offender is dependent on drugs or has a propensity to misuse drugs, providing certain conditions are met. The orders comprise structured treatment tailored to the individual's needs, with regular drug testing results being made available to the court as part of a report by the probation service. Alcohol Treatment Requirements are available when the court is satisfied that the offender is alcohol-dependent. They involve structured community-based treatment and support, which may include psychosocial therapies, interventions for assisted withdrawal, 'detoxification' and cognitive-based treatment. Both orders require the person's consent (National Offender Management Service, 2014).

In the Netherlands, offenders with psychiatric disorders can be detained for an extended period in secure treatment centres, *after* a period in prison. This controversial system is known as the Terbeschikkingstelling or 'TBS' (meaning 'at the state's discretion'). Its function is to provide compulsory psychiatric treatment with a view

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27 A person appearing to a police constable to be suffering from a mental health disorder – defined as a mental illness, a learning disability or a personality disorder – can be detained in a 'place of safety' for up to 72 hours under Section 136 Mental Health Act 1983 (by default, this is often a police station due to lack of more suitable alternatives).

28 As reported by a participating psychologist: <https://thepsychologist.bps.org.uk/volume-28/august-2015/street-triage-what-why-and-how>

29 The Verdins principles, as set out by the Supreme Court of Victoria, in *R v Verdins*, *R v Buckley* and *R v Vo* [2007] VSCA 102 (23 May 2007). The same principles could give rise to *harsher* sentencing approaches and lengthy custodial terms where, for example, the offender's mental health is considered unlikely to improve with treatment and represents a risk to public safety.

30 The Sentencing Council, 'Sentencing children and young people: overarching principles and offence specific guidelines for sexual offences and robbery' Definitive Guideline (June 2017), (paragraph 1.12)

to reducing reoffending risk (de Boer & Gerrits, 2007). The TBS can be imposed at the point of sentencing in any case where the prison term is at least four years and the court is satisfied there is a mental disorder.

The Netherlands is known for its sparing use of custody and its legal requirement of proportionality in sentencing.<sup>31</sup> By contrast, the TBS element of a sentence is open-ended and can be of long duration: 20 per cent of patients are deemed unlikely ever to be discharged after six years' detention (Maden & Newman, 2017). Criticism of the system has centred on its unlimited nature and on the difficulty of challenging continued TBS detention. There is also an apparent contradiction in a sentence that punishes first and treats later, despite a need for treatment having been made out at the point of sentencing.

### 4.3 Improving conditions and health provision in custody

Prisons are not easy places in which to provide healthcare, for a variety of reasons (Ginn, 2012), but when they are overcrowded, health provision will be severely compromised, as we have seen from the prisoner accounts featured in this report. Therefore, for most countries, reducing prisoner numbers overall is an essential first step in improving conditions of imprisonment and increasing access to healthcare and treatment.

Healthcare services and treatments for people in prison should reflect their (often highly complex) needs and should be equivalent to the services and treatments provided in the wider community. Effective practice depends to some extent on how well different services and agencies in the health and justice sectors collaborate. It also requires clarity of responsibility for the health of people passing through the criminal justice system, including prisoners.

*The prison doctor comes only once a week. There are two clinical officers interchanging and if you say you're feeling ill, they give you paracetamol at most. Usually, the doctor will assume you're lying about your health and ignore you.*

*A few times women went on hunger strike to help get a sick prisoner taken to hospital... One time a woman couldn't feed her baby daughter due to breast pain. The baby wouldn't stop crying, the women would shout at her to feed the baby but she couldn't. Eventually they discovered she had cancer.*

Female ex-prisoner 2, Kenya

In countries where prisons are overseen by justice ministries, it is often unclear where responsibility for prisoner healthcare lies. This can lead to gaps in provision. In England and Wales, prison health is now the responsibility of the National Health Service. This arrangement should at least in theory make it easier to achieve equality of healthcare provision and help to maintain continuity of care for people who enter and leave custody. (In reality, staff shortages and an already stretched National Health Service can mean patchy or poor standards of provision (see House of Commons Health and Social Care Committee, 2018).) In the Netherlands, by contrast, healthcare in prisons is the responsibility of the Justice Ministry but prisons are legally required to provide healthcare equivalent to that which is provided outside prison.

Below we discuss interventions and research capable of raising standards of mental healthcare provision in prison, before turning to those relevant to physical health.

#### 4.3.1 Mental health

Even if greater use is made of community-based interventions, it remains likely for the foreseeable future that prisons in much of the world will hold a high proportion of people with challenging mental health needs. It is important that the necessary care and treatment is provided for them, both while they are in prison and on their release.

Treatment options in prison may be limited compared to services provided in the community; but in any prison, it should be possible to provide basic interventions. These may include psychological support through counselling (from a psychologist, a nurse, or a trained prison officer or prisoner) and treatment to stabilise addiction and

<sup>31</sup> Netherlands Penitentiary Principles Act 1998 (*Penitentiaire beginselenwet*)



*The prolonged exposure to [overcrowded, unhealthy conditions] is closely associated with the establishment of complex trauma, or, put differently, toxic stress. Indeed, prolonged exposure to traumatic circumstances can lead to a complex post-traumatic stress disorder as a result of continually having to be alert, vigilant and on the defence. Continued stress of this nature leads to a shift in brain chemistry whereby cortisol is elevated to an unhealthy level. This renders detainees highly susceptible to illness and disease on a physical level as well as post-traumatic stress on a psychological level.*

Paragraph 25, affidavit of A Smit, expert witness,

*Sonke Gender Justice v. the Government of South Africa, 2016)*

manage some forms of mental illness. If a person has intellectual disabilities, practical and tailored support can be put in place to ensure that the associated risks are managed.

For some people, prison may be the first time in their lives that a mental health need is identified or support is provided. Recent research suggests that time in prison can produce improvements to mental health (for example Dirkzwager, 2018). The 'Prisons Project NL' research team led by Dirkzwager found that individuals who had mental health or substance use problems before imprisonment reported improvements in their symptoms and level of mental health after the first few weeks in custody. Reasons posited included that prisoners had often come from situations of deprivation and disorder into a more stable environment with access to healthcare. The decent and humane prison conditions prevailing in most prisons in the Netherlands may also be a factor.

Whether mental health improvement can occur in custody will of course depend on the prison conditions and environment and on the availability of care and treatment. Below, we describe some approaches that can help prisons to respond to mental health risks and needs and provide environments that safeguard mental health.

### **Mental health screening in custody**

As soon as practicable, qualified staff should carry out detailed assessments on each new prisoner to assess his or her current mental health, inquire about the person's prior mental health and any treatment history. This should include checking for any substance use issues, intellectual disabilities, age-related cognitive impairments, or other matters that could make the prisoner more vulnerable in custody. It is also important to monitor any conditions identified and ensure staff share information effectively and obtain clinical assistance where needed (World Health Organization, 2014).

Custody also provides an opportunity to screen for and treat conditions associated with traumatic brain injury (TBI), which are common in criminally-involved populations but are often left undiagnosed (see section 2.2 above). The options include:

- making greater use of screening programmes (such as those discussed in Williams et al, 2018)
- providing treatment through neuro-rehabilitation techniques
- using forensic interventions to manage the cognitive and behavioural disorders caused by or correlated with TBI
- raising awareness among relevant professionals coming into contact with people who may have suffered TBI.

### **Prison staff and mental health awareness**

Prison policies and the attitudes of prison staff are critical to protecting the mental wellbeing of prisoners, by preventing mental health issues from developing or worsening and by improving the situation of prisoners with mental illness. Conversely, negative and stigmatising attitudes by staff can mean that prisoners feel unable to ask for help when they need it. Prisoners in England (where levels of suicide and self-harm have risen to an

all-time high (Ministry of Justice, 2019)) were recently consulted about what was needed to keep them safe and reduce the risk of self-harm and suicide. They emphasised the importance of good professional relationships between staff and prisoners in helping ensure prisoners' mental health needs were met.<sup>32</sup>

Penal Reform International has issued guidance for prison staff to help them understand and respond appropriately to the mental health needs of adult prisoners (Penal Reform International, 2018). Produced with input from mental health experts and practitioners, the guidance aims to help prison staff understand and respond appropriately to the mental health needs of adult prisoners. It describes how prison staff can promote and protect mental health and wellbeing and enable those with existing conditions to cope in prison.

### **The prison's 'social climate'**

The fostering of healthy social climates in prisons has been recognised as a potential route to better mental health and wellbeing among prisoners and staff (Bennett & Shuker, 2017). Elements of practice may include: providing regular opportunities for group and individual therapy; promoting empowerment and inclusion through democratic decision-making processes; and ensuring respectful interaction among prisoners and staff. Evaluations suggest that healthy social climates help to militate against some of the negative effects of the prison environment, while helping address prisoners' mental health needs. Positive effects have been found to include reduced self-harm, improved conduct in custody and lower re-offending levels.<sup>33</sup>

A healthy social climate in prison is also characterised by greater respect for the diversity of the prisoner community and its members' specific health needs. This can enable a stronger focus on the distinct health needs and vulnerabilities of particular groups. This in turn could foster greater inclusion and ensure there is no discrimination in making available opportunities or information that could benefit prisoners' overall health and wellbeing.

### **Mental health of older prisoners**

Assessing and responding to the mental health needs of older offenders is a significant challenge for prison health systems and community psychiatric and social care services. It is important to ensure older prisoners have access to mental healthcare services for the timely assessment and diagnosis of dementia and related impairments. Prisons should also play their part in modifying the known risk factors for dementia, by ensuring healthy diets, keeping prisoners away from smoke-filled areas, and ensuring there are opportunities for exercise, fresh air and social interaction (Cipriani et al, 2017).

Dementia remains a hidden problem in prisons for many reasons, but better screening of older prisoners could help improve diagnosis of the condition and lead to appropriate treatments and adjustments. Australian research has identified the need for a more systematic and co-ordinated approach to help manage the health burden arising from steady increases in numbers of incarcerated older people (Ginnivan et al, 2018). Dementia literacy training and screening protocols have been cited as beneficial to both staff and prisoners.

Even if these adaptations and provisions are made, it remains questionable whether prisons are ever appropriate places to hold people with severe or even moderate dementia. There comes a point at which a prisoner's level of impairment would render them incapable of either reflecting on their own offending behaviour, engaging in meaningful rehabilitation, or committing further crimes (particularly if they are also physically disabled). Regular re-assessment of mentally impaired older prisoners could help inform timely decisions about whether alternative care arrangements would be more humane and effective.

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32 Independent Advisory Panel on Deaths in Custody, written evidence to House of Commons Health and Social Care Select Committee (inquiry into prison health), dated July 2018, available here: <https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/inquiries/parliament-2017/prison-healthcare-inquiry-17-19/publications/>

33 The social climate concept draws on Liebling and colleagues' system of measuring the quality of prison life (MQPL) as experienced by staff and prisoners and analysing the resulting data to produce MQPL scores for individual prisons (Liebling et al, 2011).

### 4.3.2 Physical health

#### Communicable diseases

The risks of contracting life-threatening diseases are greatly increased by prison overcrowding and poor living conditions, as discussed in Chapter 3 with reference to Brazil and South Africa. This demonstrates the importance of reducing overcrowding and improving conditions as an essential pre-condition to limiting these risks.

Good prison healthcare practices are also essential. This includes screening on reception into prison, vaccination programmes and speedy access to treatment, medicines, education and advice, including through effective collaboration with community health services.

The use of harm reduction methods in prisons (for example, supplying condoms and syringes and establishing opioid substitution programmes) is also essential for controlling risk of disease transmission. The global take-up of harm reduction recommendations has been limited in prisons compared to wider communities, especially in low- and middle- income countries (Stone & Shirley-Beavan, 2018), despite the elevated risks of infection in and through prison populations.

Lack of funding and of political support is often the main obstacle to prison-based healthcare provision. This is exemplified by the fate of recent plans to improve prison healthcare in Brazil. In 2014, a new national plan was adopted to tackle tuberculosis, HIV/AIDS and other communicable diseases.<sup>34</sup> The underlying principle was that prisoners should have access to the same level of healthcare services as those available for the general public. This was to be achieved by means of extra budget provision and greater integration of local health services and prisons. Unfortunately, the federal budget crisis of 2015 prevented the reforms from being implemented. They are now unlikely to take effect for the foreseeable future, following the change of government in 2018 and the new administration's pledges to increase the use of imprisonment, create harsher regimes and lower the age of criminal responsibility.<sup>35</sup>

*When I arrived... I told them that I was HIV positive. They never gave me my anti-retroviral treatment even though I had told them my status and asked them for medication. ...*

*As a result of my detention... my viral load has increased.*

Male remand ex-prisoner 3, South Africa

#### Non-communicable diseases

Significant extra demands fall on prison administrations if they are to make appropriate healthcare provision for the increasing numbers of prisoners suffering from chronic illnesses.

Most prisons have been designed to hold a younger, fitter population. There are challenges in safely housing prisoners who are physically infirm as a result of hypertension, diabetes, obesity, asthma or other respiratory diseases. The humane management of prisoners with chronic conditions or physical

*I have type 1 diabetes so I have to have insulin 4 times a day, taken at meal times. But in prison, I'd have to do [the final injection] much earlier than I normally would, 4.30 or 5pm, when they bang you up. They couldn't bring it to your cell later cause of staff shortages. I'd have to go from 5pm to 8am with no access to testing equipment or insulin. It was scary. You can feel really anxious if you don't have access to your kit or insulin.... You have nightmares – 'might I slip into a hypoglycaemic coma?' I felt so anxious I stole a testing kit and hid it in my mattress.*

Ex-prisoner, England

34 The plan can be found here: [http://bvsmis.saude.gov.br/bvs/saudelegis/gm/2014/pri0001\\_02\\_01\\_2014.html](http://bvsmis.saude.gov.br/bvs/saudelegis/gm/2014/pri0001_02_01_2014.html). For additional resources: <http://dab.saude.gov.br/portaldab/biblioteca.php?conteudo=legislacoes/pnaisp>

35 All candidates for presidency are required to submit to Brazil's electoral authority a 'programme for government'. Candidate Bolsonaro's was contained in a Powerpoint presentation (<http://www.tse.jus.br/arquivos/jair-bolsonaro-proposta-de-governo-1o-turno>), which proposed: 'zero tolerance for crime and corruption' (slide 10); 'to arrest, incarcerate and keep incarcerated'; and to 'end temporary leave and progression [from higher to lower security regimes]' (slide 32).

disabilities requires substantial adjustments to the physical environment. For example, narrow cell doorways make it impossible to enter in a wheelchair; and bunk beds or very low fixed beds will be impossible for disabled or frail prisoners to use.

Prisoners with chronic diseases are entitled to the same standard of care and treatment in prison as they would receive in the community. This will usually mean provision of primary care within the prison to the extent possible, together with outpatient appointments in the community where necessary. For those prisoners who have serious physical disabilities, or who require end-of-life care, a humane approach will require consideration of alternative, non-custodial provision.

Non-communicable diseases place significant additional burdens on prison healthcare systems, but they are preventable, chiefly by interventions to control their principal causes.

Preventive work is a key part of limiting the risks of non-communicable disease in prisoners and the associated healthcare costs. Research has shown the capacity of prison regimes to reduce risk factors for non-communicable diseases by carrying out regular, detailed health checks and by introducing measures to promote healthier living. (See, for example, Butler & Milner, 2003.)

Prisoners should receive advice and education materials on healthier living and regular health screening. Prisons may consider banning smoking in shared areas. A nutritionally adequate and balanced diet should be provided (catering for the distinct dietary needs of women and of people who wish to observe religious dietary rules). If prisoners are allowed to buy food and snacks, these should be healthy and not highly processed. Providing appropriate opportunities for prisoners to exercise is also a key preventive measure. Healthy diets, together with exercise and the social interaction it brings, have been shown to have physical and mental health benefits, with improved conduct and inter-personal relationships in custody reported (World Health Organization, 2014).

*The food was never enough, it was never warm, and was not cooked properly. Even pigs would reject it .*

Female ex-prisoner 1, Kenya

The implementation of healthy regimes is greatly hindered by prison overcrowding, as it generally leads to reduced space for exercise and limited staff supervision time. Reducing overcrowding is therefore an essential precondition to ensuring that prisons can control risks for non-communicable diseases.

*If you tell them you have TB they isolate you and take you to TB ward, but the medication is only available sometimes, not all the time, so often its days before you get what you need.*

Female ex-prisoner 2, Kenya

#### 4.3.3 Continuity of care

Continuity of care for prisoners is important across the whole custody process. This means assessing on reception into custody whether the prisoner was receiving treatment in the community and ensuring any necessary medication is continued in prison.

Effective continuity also requires individualised preparation for release, including proper handover of the prisoner's care to community-based services. This is particularly important in the context of prisoners with a history of mental health problems or substance issues. The heightened risks of overdose or relapse should be managed. Compared to the general population, people released from custody face a very high risk of premature mortality from opioid-related overdose. This risk can be reduced by

making naloxone, a medication that reverses opioid overdose, available upon release (Stone & Shirley-Beavan, 2018). It is also important to ensure prisoners with a history of drug use are directed to support services in the community in advance of release, given the high risk of suicide associated with this group.<sup>36</sup>

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36 (See section 3.1.6 above.)

The heightened risk of suicide for released prisoners has been linked to several factors that could be managed at and immediately after release from custody, with a view to facilitating transition to life after prison (Haglund et al, 2014). Interventions include increased clinical monitoring and early involvement with community mental health services. In addition, the mental and physical health consequences of potential homelessness and unemployment should be managed and mitigated through community-based services.

Peer mentors in the form of ex-prisoners can provide valuable support for people leaving custody who need to access community health, rehabilitation and social care services. This assumes mentoring schemes are properly designed and run. (For examples of potential pitfalls and good practice in peer mentoring schemes in this context, see Fletcher & Batty, 2012.)

*I came out with lack of self-esteem, I fear other people, can't talk to people, was stigmatised, just learning to cope now, don't know if I'll be able to cope. When I got back, my partner said it was over.*

Former remand prisoner, female:  
detained for one week. Kenya

## 4.4 Conclusion

Although imprisonment can sometimes provide an opportunity to stabilise or improve the health of people with high levels of unmet health needs, the prison setting is more frequently *detrimental* to health. This is all the more so for the considerable numbers of prisoners whose health-related or other vulnerabilities place them at greater risk of harm in custody. Therefore, the primary focus of reform should be on providing more effectively for health needs – particularly those linked to mental health and drug or alcohol problems – without resort to imprisonment wherever possible.

When community health responses or treatment options are overstretched or do not exist, people who need treatment or support for mental health problems often find themselves in and out of police stations, courts and prisons instead, with all the distress and upheaval this brings. Over-reliance on criminal justice interventions when a health-led approach would be more effective leads to poor re-offending outcomes and heavier workloads for police, prosecution, court and probation services and puts added pressure on prison places. More fundamentally, it raises serious ethical questions, as discussed at the beginning of this chapter.

Prisons in developed and less developed countries alike contain large numbers of people whose health, already poor, will only worsen during their time in custody. In countries where community health standards are poor, prisons – especially overcrowded ones – will inevitably struggle to make even basic provision for disease prevention, screening and healthcare, presenting major risks for public health. The important goals of rehabilitation and preparation for release are defeated when there are no resources to achieve them, or when conditions and healthcare provision are so poor as to threaten prisoners' health.

When a state's justice and health policies lead to the systemic incarceration of people whose healthcare needs cannot be met in the prevailing prison conditions, those policies will infringe constitutional and international human rights protections. This has been established in proceedings against some of the ten countries discussed in this report. Jurisdictions have been ordered to reduce their prison populations in order to be capable of safeguarding prisoners' basic rights to healthcare.

The urgent questions that are thus raised for every government include:

- Whether all available routes are being pursued to prevent overcrowding in prisons and thereby minimise the associated risks to public health; and
- How the work of criminal justice and community health agencies can be reconfigured to prevent the imprisonment of people whose health needs could be better met in the community.



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# APPENDIX: Standards and Further Reading

## International human rights instruments

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## Regional human rights instruments

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## Institute for Criminal Policy Research

The Institute for Criminal Policy Research (ICPR) is based in the Law School of Birkbeck, University of London. ICPR conducts policy-oriented, academically-grounded research on all aspects of the criminal justice system. ICPR's work on this report forms part of the ICPR World Prison Research Programme, a programme of international comparative research on prisons and the use of imprisonment. Further details of ICPR's research are available at <http://www.icpr.org.uk/>

ICPR's book, *Imprisonment Worldwide: The current situation and an alternative future* (Coyle, Fair, Jacobson and Walmsley) was published in June 2016 and is available from Policy Press.

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## World Prison Brief

The World Prison Brief was established by Roy Walmsley and launched in September 2000 by the International Centre for Prison Studies. Since November 2014 the Brief has been hosted and maintained by the Institute for Criminal Policy Research. The data held on the Brief (which is updated on a monthly basis) are largely derived from governmental or other official sources. The data used in this report were accessed from the database between March and May 2019. The World Prison Brief can be accessed at <http://prisonstudies.org/>