

DIGNITY MANUAL

MONITORING HEALTH IN PLACES OF DETENTION

AN OVERVIEW FOR HEALTH PROFESSIONALS



MONITORING HEALTH IN PLACES OF DETENTION

An Overview for Health Professionals

By Brenda van den Bergh, Lisa Michaelsen, Marie Brasholt and Jens Modvig

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FOREWORD

Globally, over 11 million people are imprisoned, which is the highest number ever reported. In many countries all over the world, places of detention are of suboptimal standard and unfortunately treatments and conditions too often violate international human rights standards.

Being detained is a serious punishment in itself and conditions and treatments in places of detention should not aggravate this punishment. Prisoners retain their fundamental human rights, including the right to be free from torture and other cruel, inhuman or degrading treatment or punishment and the right to health and health care, equivalent to people living in the general community. Unfortunately, we often see that these rights are being violated with prisoners residing in conditions that are detrimental to their health, being treated in ways that make their health deteriorate, and having no or poor access to health care services. This may amount to ill-treatment and, in extreme cases, to torture, as defined in the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. Prison authorities have a responsibility in ensuring the right to health for all by having a well-functioning prison health service as well as decent conditions and treatments in place.

Monitoring places of detention by an independent body is key to evaluate conditions and treatments in places of detention and to assess whether these are in line with international standards. It is known to be one of the most effective ways to prevent torture and ill-treatment. Monitoring health is an essential component of monitoring places of detention. This includes assessing the prisoners' health, the health care services available to them and the conditions and treatments that have a direct or indirect impact on their health. It involves looking into a broad range of issues, including the accessibility of the health care services, the initial medical assessment of prisoners upon entry, the equivalence and continuity of care, the treatment and care of prisoners with a substance use disorder or with a mental health problem, the handling of hunger strikes, the nutrition, sanitation and hygiene in the place of detention, and many others.

This manual aims to provide a comprehensive overview of all prison health aspects that are relevant when monitoring health in places of detention and is primarily aimed at health professionals conducting monitoring visits as part of an independent monitoring body. The manual discusses the preventive monitoring approach, the monitoring cycle and includes 33 chapters in which individual prison health aspects are being presented and discussed in detail, taking a base in prevailing international human rights standards and the relevance to preventive monitoring. It needs to be noted that the current version is a first version of the manual. The intention is to publish a second version, including practical monitoring tools, at later stage.

We hope that this manual will be a useful guide for everyone interested in monitoring health in places of detention and that more comprehensive monitoring practices will contribute to improving life for those residing in those places.

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Moreover, we would like to express our sincere thanks to all organizations around the world that have done important work in the areas of health in places of detention and preventive monitoring. These organizations can all be found in the references throughout the manual. The key references used are listed in annex 1. We would like to give a special thanks to the following organizations and associations for their fantastic work in the areas of health in places of detention and preventive monitoring: the Association for the Prevention of Torture, the International Committee of the Red Cross, the Physicians for Human Rights, Defence for Children International, and the World Medical Association. Furthermore, we would like to express gratitude to the European Court on Human Rights for their extensive case descriptions, which have been used as examples in many chapters. Moreover, we are thankful to the Danish Ombudsman and the Danish Institute for Human Rights for our yearlong collaboration in the Danish National Preventive Mechanism, which has given us extensive experience in health monitoring as well as examples, some of which are presented in this manual.

Finally, we thank our donors for their financial support which allowed us to develop and publish this manual.

SECTION 1: INTRODUCTION TO MONITORING HEALTH IN PLACES OF DETENTION

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”¹

1.1. Aim and target audience of this manual

Monitoring places of detention by an independent body is one of the most effective ways to prevent torture and ill-treatment of people kept in those places.² Health is an integrated part of life and health services offered to persons deprived of their liberty should be equivalent to those available to persons living in the general society. Being deprived of such services while detained or residing in conditions detrimental to a person’s health and well-being, may amount to ill-treatment and, in extreme cases, to torture.

This manual focuses on monitoring health aspects in places of detention. It is assumed that the reader has already a basic understanding of preventive monitoring of places of detention on torture and ill-treatment. The manual will therefore not address in great detail general issues related to preventive monitoring and merely gives a brief summary of key concepts in the next chapter. For detailed guidance on how to conduct preventive monitoring of places of detention, this manual refers to already available guidance, including the ‘Training manual on human rights monitoring’ published by the United Nations Office of the High Commissioner for Human Rights in 2001,³ ‘Monitoring places of detention. A practical guide’ published by the Association for the Prevention of Torture in 2004,⁴ and the ‘Practical guide on monitoring places where children are deprived of liberty’ published by Defence for Children International in 2016.⁵

The main target audience of this manual consists of health professionals, including but not limited to medical doctors, nurses and public health specialists with an interest in, or official capacity related to, monitoring health aspects in places of detention. Both new health monitors as well as health monitors who already conduct monitoring visits will benefit from reading this manual. The aim of the manual is to provide the reader with an overview of health aspects to take into account before, during and after a monitoring visit, functioning as a key reference book. The individual chapters in Sections 3, 4 and 5 could function as read-alone chapters on a specific topic.

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- 1 WHO (1948). *Constitution of the World Health Organization*. Geneva, 1948. Available at: <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>
 - 2 APT (2016). *Yes, torture prevention works. Insights from a global research study on 30 years of torture prevention*. Association for the Prevention of Torture, Geneva, September 2016. Available at: https://www.apr.ch/content/files_res/apr-briefing-paper_yes-torture-prevention-works.pdf. Carver and Handley (2016). *Does torture prevention work?* Liverpool University Press, 2017.
 - 3 UNOHCHR (2001). *Training manual on human rights monitoring*. United Nations Office of the High Commissioner on Human Rights, New York and Geneva, 2001. Outline available at: <https://www.ohchr.org/documents/publications/training7intro-en.pdf>
 - 4 APT (2004). *Monitoring places of detention. A practical guide*. Association for the Prevention of Torture, Geneva, April 2004. Available at: https://www.apr.ch/content/files_res/monitoring-guide-en.pdf
 - 5 DCI (2016). *Monitoring places where children are deprived of liberty. Practical guide*. Defence for Children International, Belgium, 2016. Available at: <https://defenceforchildren.org/wp-content/uploads/2016/02/DCI-Practical-GuideEN.pdf>

The manual is aimed to lead to more professional and comprehensive health monitoring practices, with the ultimate impact of prevention of torture and ill-treatment and improving conditions and services for people kept in places of detention.

1.2. Monitoring places of detention

This chapter includes a brief overview of key concepts and information on monitoring places of detention with a view to prevent torture and ill-treatment. It is written as a summary and recapitulation of basic knowledge on preventive monitoring, which the reader is assumed to be mostly familiar with by experience and/or existing guidance.

Monitoring places of detention could best be described as *'a systematic process of observing, tracking, and recording activities or data for the purpose of measuring the performance and ill-performance of a prison (system).'* It refers to monitoring with a focus on the conditions of detention (for instance the facilities, but also the protection against diseases and violence) and the treatment of people in detention (for instance the staff-prisoners relationship and available activities) as well as on the compliance of these conditions and treatment with national and international standards for the protection of human rights and, in particular, the protection against torture and ill-treatment.

There are several national and international bodies monitoring places of detention. At the national level these include internal inspections, judicial inspections and independent external inspections, foremost by national human rights institutions and sometimes non-governmental organizations (NGOs) working in the area of human rights. Only the independent external inspections can be expected to operate with a preventive monitoring approach. States that have ratified the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) are moreover required to install a National Preventive Mechanism (NPM), conducting preventive monitoring of places of detention in the country.

At the international level, a number of monitoring bodies are operational. These include the monitoring mechanisms by the International Committee of the Red Cross (ICRC) and the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) (also installed under the OPCAT). At regional level, the European Committee for the Prevention of Torture (CPT) and the Inter-American Commission on Human Rights are examples of independent, preventive monitoring bodies operational in Europe and America respectively.

This manual focusses on *preventive* monitoring, which can best be described as monitoring with a dual view, i.e. to:

1. Identify existing breaches of standards, e.g. cases of torture or ill-treatment; and
2. Identify conditions and treatment, which may develop into breaches of standards.

Preventive monitoring can therefore be described as *'the well-prepared systematic and regular observation and recording of conditions and treatment of prisoners in places of deprivation of liberty. The monitoring involves the validation of the findings, the evaluation of the findings in light of national and international standards, the analysis of the causal background for the findings, making recommendations in order to promote improvement and preventing future cases of torture and ill-treatment, as well as following up the implementation of these recommendations'.*

It is important to note that sometimes national and international standards may be conflicting (e.g. on how to handle a hunger strike, see the respective chapter in Section 3). In these cases, the monitor should make a sound judgement as to which standards to refer to and should be informed about why national standards deviate from the international standards.

Preventive monitoring is assumed to contribute to the prevention of torture and ill-treatment by means of three distinctly different mechanisms:

1. Cases of torture and ill-treatment are identified, analyzed and brought forward, and the failure of existing protection mechanisms are pointed out. Recommendations for the amendment of the failures of protection are made at the appropriate level of responsibility (institution management, ministry, parliament). If the protection is improved, future cases are prevented.
2. Conditions and treatment, which – if further amplified – may give rise to torture or ill-treatment, are identified in an early stage, analyzed and brought forward with a view to stop their further development at the appropriate level (institution, central administration, parliament), thereby preventing the occurrence of torture and ill-treatment.
3. The general deterrent effect of monitoring entails that just the fact that independent outside experts come on a regular basis and review conditions and treatment, will discourage staff to overstep lines and ensure transparency and accountability with regard to ensuring compliance with standards.

The main international standard referred to throughout this manual is the United Nations (UN) Mandela Rules.⁶ The Mandela Rules are an updated version of the UN Standards Minimum Rules for the Treatment of Prisoners (1963) and were published in 2015. Although they are not legally binding, they are often regarded by States as the primary – if not only – source of standards relating to conditions and treatments in detention, and are the key framework used by national, regional and international monitoring and inspection mechanisms around the world in assessing and monitoring places of detention.

Basic Rule number 1 of the Mandela Rules clearly provides the framework for any monitoring work:

'All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times'.

Other international standards and conventions and protocols which the health monitor should be familiar with, include (but are not limited to):

- The UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules), United Nations, New York, 2011.
- The UN Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules), United Nations, 1985.
- The UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, United Nations, 1984.
- The Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, United Nations, 2006.

⁶ UN (2015). United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules). United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

- The Istanbul Protocol; Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment, Office of the UN High Commissioner for Human Rights, 2004.
- The European Prison Rules, Council of Europe, Strasbourg, 2006.⁷
- The CPT Standards 2002, revision 2010, European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010.

Monitoring places of detention is by nature a sensitive and difficult task. The following basic principles are always key to adhere to:

1. Do no harm
2. Respect the mandate
3. Know the standards
4. Exercise good judgement
5. Seek consultation
6. Respect the authorities and the staff in charge
7. Respect the persons deprived of liberty
8. Be credible
9. Respect confidentiality
10. Respect security
11. Understand the country
12. Be consistent, persistent and patient
13. Be accurate and precise
14. Be impartial
15. Be objective
16. Be sensitive
17. Behave with integrity
18. Behave professional
19. Be visible^{8,9}

Monitoring should be seen not only as a control and inspective measure of what is going on in places of detention, but also as a cooperation between monitors and the various groups of actors in the institution, with the aim of ensuring the dignity and rights of prisoners.

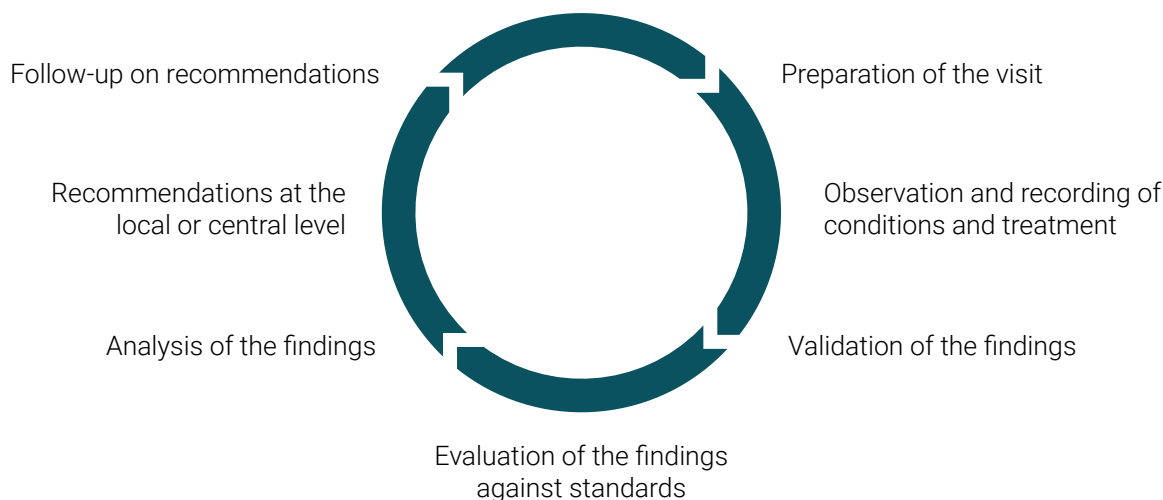
The phases of preventive monitoring can be represented as a monitoring cycle running repeatedly, as demonstrated in figure 1.

7 In the European Region, the Council of Europe published the European Prison Rules, originally published in 1987 and updated in 2006. The European Prison Rules are based on the original UN Standard Minimum Rules for the Treatment of Prisoners as published in 1957. They are not legally binding for member states of the Council of Europe, but provide recognized standards on good principles and practices in the treatment of detainees and the management of detention facilities. They are often used as a main reference for inspection and monitoring mechanisms for places of detention in the European Region.

8 UNOHCHR (2001). *Training manual on human rights monitoring*. United Nations Office of the High Commissioner on Human Rights, New York and Geneva, 2001. Outline available at: <https://www.ohchr.org/documents/publications/training7intro-en.pdf>

9 APT (2004). *Monitoring places of detention. A practical guide*. Association for the Prevention of Torture, Geneva, April 2004. Available at: https://www.apr.ch/content/files_res/monitoring-guide-en.pdf

FIGURE 1.
THE MONITORING CYCLE



A great number of actors are involved in the conditions of places of detention and treatment of prisoners, including law makers, the government, ministries, the prison administration, the management of the individual institution, prison staff members, prison health staff members and the general public. Among all those actors, monitors will mostly deal with the management of the individual institution, its staff members and health staff members. There may be conflicting interests between actors from these three groups and between the three groups and other actors, which the monitor should always keep in mind.

Holding authorities accountable for their human rights and public health obligations is always challenging in places of detention and therefore, the work of monitors is crucial.

Further reading

APT (2004). *Monitoring places of detention. A practical guide*. Association for the Prevention of Torture, Geneva, April 2004. Available at: https://www.apr.ch/content/files_res/monitoring-guide-en.pdf

DCI (2016). *Monitoring places where children are deprived of liberty. Practical guide*. Defence for Children International, Belgium, 2016. Available at: <https://defenceforchildren.org/wp-content/uploads/2016/02/DCI-Practical-GuideEN.pdf>

OSCE ODIHR and PRI (2018). *Guidance document on the Nelson Mandela Rules. Implementing the United Nations Revised Standard Minimum Rules for the Treatment of Prisoners*. OSCE Office for Democratic Institutions and Human Rights and Penal Reform International, 2018. Available at: <https://www.osce.org/odihr/389912?download=true>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UNOHCHR (2001). *Training manual on human rights monitoring*. United Nations Office of the High Commissioner on Human Rights, New York and Geneva, 2001. Outline available at: <https://www.ohchr.org/documents/publications/training7introen.pdf>

UNOHCHR (2006). *Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment*. United Nations Office of the High Commissioner on Human Rights, New York and Geneva, 2006. Available at: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx>

1.3. Health monitoring and the health monitor

When looking specifically into the health aspects in a place of detention and the health consequences related to the conditions of the place as well as the treatment of the prisoners, this is referred to as health monitoring.

'Health monitoring of places of detention is the well-prepared and regular observation and recording of health aspects and health consequences related to conditions of detention and treatment of prisoners in places of detention'

Preventive health monitoring looks into:

1. Conditions and treatments affecting the health of prisoners in places of detention, which breach national and international human rights standards and represent a risk to the health of prisoners; and
2. Conditions and treatments affecting the health of prisoners in places of detention, which *may develop into a breach* of national and international human rights standards.

As part of a monitoring team with an extensive mandate to prevent torture and ill-treatment, monitors with a specific focus on health aspects are in a unique position to help promote and protect prisoners' health and human rights through consistent monitoring of all aspects relating to health.

As will be elaborated in more detail in the next Section, health monitoring looks into 3 areas, together referred to as the prison health framework:

1. The health of the prisoners kept in the place of detention
2. The health services available to the prisoners
3. The factors in the place of detention that directly or indirectly impact on the health of the prisoners

Health monitoring can best be conducted by persons with a health-specific background. Medical specialists, such as general practitioners, psychiatrists and dentists, are often first choice for conducting health monitoring due to their knowledge of health conditions, medications and the necessary elements of an effective health care service. Their extensive educational background, knowledge of the level of provision of health services in the general society, and experience with working with patients makes them the obvious choice to conduct health monitoring. Nurses, public health specialists and other health professionals also have a good understanding of the most common health conditions and the functioning of health care services and are therefore considered qualified health monitors as well. What is most important for a person monitoring health aspects in a place of detention, is a basic background knowledge on health conditions and health services - in particular in places of detention, but also in the outside community - and on the influence of prison factors on health. Moreover, the person should be familiar with the general approach to preventive monitoring of places of detention. He/she should be skilled in conducting interviews for monitoring purposes. He/she should have (at least some basic) experience with and knowledge on identifying victims of torture and ill-treatment and (basic) documentation of such cases. He/she should know the most common torture methods in the local area and be familiar with their consequences on the physical and mental health of the victim (see Section 6 on torture methods and their consequences).

Preferably, the health monitor should not conduct monitoring visits on his/her own and instead be an integral team member of a monitoring body consisting of a broad range of professionals. He/she should contribute to the overall recommendations of the monitoring body with his or her specific expertise.

1.4. Role of the health monitor in the monitoring team

The health professional has a specific mandate in the monitoring team to focus on the health aspects in the place of detention. During the monitoring visit, he/she will be the team member that should ensure that monitoring health aspects is conducted in its entirety and that the prison health services are properly assessed. This will necessitate the cooperation and coordination with other team members who could – during interviews with prisoners - gather information on for instance access to the prison health clinic, diagnostic means and medicine, and for instance inquire on corruption related to health services which is an important issue in some countries. Other team members could also refer prisoners to the health monitor for an assessment of whether the offered medical services have been (in)sufficient or for an assessment of and follow-up on an allegation of torture or ill-treatment.

It is important to stress that the health professional participates in a monitoring team within the overall mandate of the team, i.e. preventive monitoring. The task of the health professional in the monitoring team does therefore not include examination and treatment of individual prisoners (examination only in very exceptional cases, see also Section 2.2.1). Nor is it the role of the health professional to review the medical treatment provided in individual cases. However, an overall and general evaluation of the quality of the health care provided is included in the tasks of the health monitor in order to assess compliance with the principle of equivalence of care.

A health professional is in the best position to fully assess all aspects of a place of detention that impact upon health, discuss specific health issues with prisoners and with the authorities (with power and influence), assess the health services in the place of detention and the treatment and care being provided, and provide essential medical expertise in the prevention and identification of torture and ill-treatment.

Further reading

APT (2008). *Visiting places of detention. What role for physicians and other health professionals?* Association for the Prevention of Torture, Geneva, 2008. Available at: https://www.apr.ch/content/files_res/RoleForPhysicians.pdf

1.5. Key concepts and definitions

Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.¹⁰

Ill-treatment

Ill-treatment equals cruel, inhuman, or degrading treatment or punishment. Ill-treatment is a broader term than torture, referring to a broad range of acts that amount to cruel, inhuman or degrading treatment or punishment. This could for instance include prolonged solitary confinement, poor nutrition, poor sanitation and ventilation and severe overcrowding. It is not always easy to make a clear distinction between torture and ill-treatment and ill-treatment may be categorized as torture when considered very severe and inflicting a high level of pain or suffering. It is important for a monitor to realize that this distinction is in the end not so important. Anything that he/she encounters while monitoring a place of detention which may amount to torture or ill-treatment, should be included in his/her focus. There are in principle two forms of ill-treatment:

1. An aggravated form of pain or suffering arising only from, inherent in or incidental to lawful sanctions, i.e. non-intentional and without any obvious purpose;¹¹
2. Intentional infliction of suffering for a purpose (e.g. during interrogation), but not meeting the severity level qualifying it as torture.

Place of detention

A place of detention is a place where people reside who are deprived of their liberty. It is a place of compulsory detention in which people are confined while on remand awaiting trial, on trial or for punishment following conviction for a criminal offence because they have been convicted of a crime (not including police cells). Without aiming to be an exhaustive list, this includes prisons, pre-trial detention facilities, arrest houses, police detention, psychiatric hospitals, social care homes, military detention camps, and detention centers for migrants.¹²

In this manual, the terms 'prison' and 'institution' are often used as a synonym for place of detention.

Prisoner

Any person deprived of personal liberty as a result of arrest, administrative detention, pretrial detention or conviction and held in a place of detention.

In this manual the term 'prisoner' is used as a synonym for 'detainee' or 'inmate'.

Torture

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a con-

10 WHO (1948). Constitution of the World Health Organization. Geneva, 1948. Available at: <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

11 UN (1984). United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. United Nations General Assembly, 1984. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx>

12 This manual mainly focusses on prisons and pre-trial detention facilities, while it will also be useful for monitoring some of the other places of detention. Monitoring psychiatric hospitals requires a particular approach and is therefore out of the scope of this manual, even though many chapters will still provide useful information for this setting.

fession, punishing him for an act he/she or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.¹³

13 UN (1984). United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. United Nations General Assembly, 1984. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx>

SECTION 2: THE HEALTH MONITORING CYCLE

Based on the monitoring cycle as outlined in Section 1, health monitoring is conducted in several steps, which can be clustered as:

1. Preparation of the monitoring visit;
2. Conducting the monitoring visit;
3. Follow-up on the monitoring visit.

2.1 Preparation of the monitoring visit

Before the actual monitoring visit takes place, a health monitor should prepare for the visit by looking into any relevant documentation that can be accessed. In addition to looking into open information sources, such as annual reports and websites, the health monitor should prior to the visit request information from the prison service and prison health service, relevant to the focus of the visit. Monitors should always consider how much detail is needed with regard to the information they request, for instance for how many years numbers are needed. The below list includes a broad range of issues on which information could be requested, and it is up to the health monitor to select the ones of relevance to the visit:

Issues to request information on prior to the monitoring visit may include:

1. Total number of prisoners and capacity of the institution
2. Information on disease incidence and prevalence
3. Information on the number of cases of suicides and suicide attempts
4. Information on the number of cases of self-harming
5. Information on the number of deaths in custody and deaths in hospital after transfer, including causes of death
6. Organization of the prison health clinic, including who are the prison health professionals reporting to, i.e. the prison service/Ministry of Justice/Ministry of Interior or the health authorities/Ministry of Health
7. Number of staff members working in the prison health clinic, including a breakdown in type of professionals
8. The capacity of the prison health clinic, i.e. number of hours of daily presence of doctors, nurses and dentists
9. Number of patient encounters per day in the prison health clinic
10. Budget of the prison health services per prisoner
11. Information regarding the initial medical assessment offered to a prisoner upon arrival – procedure, duration, focus, timing
12. Any regular medical examination offered to prisoners after arrival
13. In case the place of detention has a hospital: number of beds, number of admissions broken up into diagnoses
14. In case the place of detention does not have a hospital: number of transfers to hospitals broken up into diagnosis

15. Availability of special facilities for groups of prisoners with special needs, e.g. women, minors, prisoners with a physical disability, LGBTI, prisoners with a drug dependency
16. Number of prisoners who have been offered treatment of drug and/or alcohol dependency (including information on how withdrawal symptoms are handled)
17. The links to specialized health services: psychiatry, gynecology, surgery, infectious diseases etc. Information on whether specialists come to the place of detention or prisoners are sent to an out-patient clinic
18. Number of referrals to specialized health services inside the place of detention (consultants?) as well as to services in the community
19. The link to dental health services. Information on whether a dentist is available in the place of detention or whether prisoners are sent to a dental clinic outside
20. Type of registers kept in the prison health services, i.e. consultations by visiting specialized doctors, referrals to services outside the prison, infectious diseases, death of prisoners, etc.
21. Any written instructions available to the prison health staff or to prison guards in relation to health issues
22. Any health information campaigns addressed to prisoners
23. Any available reports addressing health-specific issues in the place of detention, either from previous visits or from other monitoring bodies and NGOs having access to the place of detention

The health monitor should try to find out in advance when the prison doctor is present, in order to ensure being able to talk to him/her during the monitoring visit.

Apart from obtaining the information as listed above, there are a number of 'indirect' monitoring sources that could be helpful in the preparation of a visit, or in case access to a place of detention is limited or non-existing. Apart from the first one (media sources) which should always be consulted, these sources will usually be used only when there is a clear reason as to why to do so, for instance a follow-up visit on a specific theme on which not enough information can be obtained from direct sources. They include:

1. Media sources (taking into consideration that they are often not first-hand testimonies and that they may have been misunderstood or manipulated).
2. Interviews with ex-prisoners
3. Interviews with family members of prisoners
4. Interviews with former prison (health) staff
5. Interviews with other monitoring bodies and NGOs with (restricted) access to the place of detention
6. Interviews with community health staff that have been involved in treatment of prisoners
7. Interviews with lawyers that may access the place of detention for the provision of legal aid.

In case that access to the place of detention is not possible at all, the indirect sources will be the only information sources available to the monitor to get a limited idea of the reality inside.

2.2 Conducting the monitoring visit

As outlined in Section 1, health monitoring concentrates on:

1. Conditions and treatments affecting the health of prisoners in places of detention, which breach national and international human rights standards;
2. Conditions and treatments affecting the health of prisoners in places of detention, which may develop into a breach of national and international human rights standards.

Conducting health monitoring means looking into these two areas in a comprehensive way. Below follows the description of a framework and working tool to facilitate health monitoring.

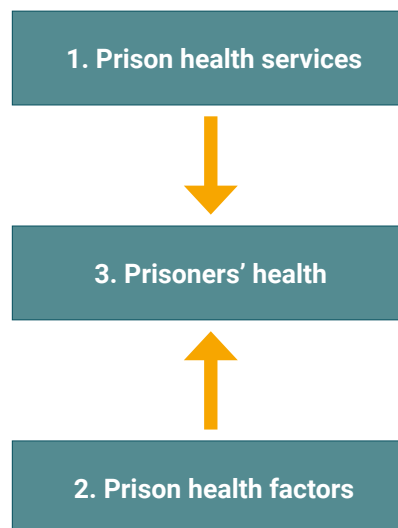
2.2.1 The prison health framework and health monitoring matrix

When monitoring conditions and treatments affecting the health of prisoners, it is important to look into a broad scale of relevant health aspects. These aspects can be clustered into three areas, i.e.

1. The health of the prisoners kept in the place of detention
2. The health services available to them
3. The factors in the place of detention that directly or indirectly impact on the health of the prisoners

The three areas together constitute the **prison health framework** as illustrated in figure 2.

FIGURE 2.
PRISON HEALTH FRAMEWORK



Prisoners' health is centrally displayed in the framework, demonstrating that both the prison health services and the prison health factors have an impact on prisoners' health.

Ad 1. Prison health services

When looking into the health care services available in the place of detention, the health monitor should not only concentrate on the availability and accessibility of the health care services, but also on the quality and acceptability of the services. Aspects to monitor under prison health

services include but are not limited to: access to these services (including role of prison guards in gaining access); the quality of these services (e.g. equivalent to those in the general society?), medical confidentiality, informed consent, and handling of medicines.

Ad 2. Prison health factors

There are many environmental, situational and procedural factors in a place of detention that may have an impact on the health of the prisoners, which are referred to as prison health factors. Monitoring these factors for their consequences on prisoners' health is an essential element of comprehensive health monitoring. Aspects to monitor under prison health factors include, but are not limited to: hygiene, nutrition, sanitation, ventilation, overcrowding, relations between prisoners and between prisoners and staff, and the prison regime.

Ad. 3. Prisoners' health

The prisoners' health status will give indications about the conditions and treatment in the place of detention and the health services available to the prisoners, both upon arrival and during their imprisonment. Also, when assessing the prison health services and the prison health factors, the health monitor will inevitably identify problematic cases with ill-health of prisoners. The analysis of such cases will confirm or amplify observations made as to the prison health services and the prison health factors. Monitors' analysis should include an assessment of whether a case represents an exception/ mishap or whether it is part of a deficient system, which may necessitate analysis of similar cases that monitors should look for. Aspects included under prisoners' health include, but are not limited to: mental health problems, substance use, non-communicable diseases and communicable diseases and gender specific health issues.

In Sections 3, 4 and 5 of this manual, the three areas of the prison health framework are outlined in detail, addressing the relevant aspects to monitor within their individual chapters.

The three health areas can be monitored by assessing different sources of information. A tool proven to be useful in this process is **the health monitoring matrix**. The health monitoring matrix lists all aspects under an area vertically and the possible information sources for these aspects horizontally. A health monitoring matrix only presenting the three overarching areas as reflected in the prison health framework, is illustrated in figure 3.

FIGURE 3.
HEALTH MONITORING MATRIX

Health monitoring matrix		Sources of information							
		Prisoners	Health staff	Prison guards	Prison management	Observations	Documents		
							Individual case records	Registers	Written instructions
Prison health services									
Prison health factors									
Prisoners' health									

The direct sources of information which should be used for monitoring the three areas of the prison health framework and which are referred to throughout this manual, are:

1. Interviews with prisoners

Interviewing prisoners about their experiences, observations, reflections, analyses, thoughts and feelings is central to monitoring places of detention. Those kept in places of detention are the best source for inside information on the prison health services and the prison health factors. Prisoners may also be willing to elaborate on their (and their fellow prisoners') health status and give examples on how these health issues have been dealt with by the prison (health) service. The information obtained from prisoners is key for a comprehensive assessment of the situation.

2. Interviews with prison health staff

Interviewing prison health staff gives a good insight into the structure and practices of the prison health services in the place of detention. It also gives the monitor first-hand information on issues such as the dual obligations that prison health professionals may experience and how these are dealt with (see the chapter on the role of the prison health professional and dual obligation dilemmas in Section 3). Prison health staff will be able to give a good picture of the main health issues in the place of detention relating to all three areas of the prison health framework.

3. Interviews with prison guards

Prison guards are in daily contact with the prisoners and will have good insights in the main issues and challenges prevalent in the institution. Although mainly referring to prison guards in

this manual, it is important to note that also other prison staff, including teachers, priests, social workers etc. can be valuable sources of information. Prison guards will have a good picture of the daily life in the prison and on how the prison health factors may influence the health and well-being of the prisoners and the staff members working in close contact with prisoners..

4. Interviews with prison management

Usually, monitoring visits start and end with a meeting with prison management where several aspects of all three areas of the prison health framework can be addressed. Prison management will often be in the position to give a good overview of basic information about the place of detention, its collaboration with systems in the community, and the main challenges the institution faces.

5. Observations

Every monitor should at any time during the monitoring visit make use of his/her possibility to observe. Simply observing the material conditions in the place of detention (such as sanitary facilities, kitchen, bedding etc.), seeing and hearing the way prisoners interact, the way prisoners and staff members interact, and the way staff members interact with each other, can give valuable information about the 'climate' in the place of detention. Observations may also include smelling and tasting, like trying the prisoners' food.

6. Documents

There is a wide variety of documents which may provide useful information for obtaining a complete picture of the health aspects in a place of detention. Documents include for instance prisoner files, medical records, written instructions and registries on for instance the use of isolation cells, the number of (attempted) suicides and the use of instruments of force, like handcuffs or pepper spray, by prison guards. In the case of an announced monitoring visit, several documents can often be requested and obtained from the prison management and Ministry prior to the visit. Depending on the mandate of the monitoring team, a monitor needs a prisoner's informed consent before looking into his/her medical record. In case an official informed consent is not required, the monitor should however always strive to be open and notify the prisoner of his/her task to look into the medical records. Apart from using the above six key information sources, the health professional in the monitoring team may in **very exceptional circumstances** conduct a basic medical examination of a prisoner. This is only relevant when a prisoner alleges to have experienced torture or has a visible medical condition which he/she claims has not been dealt with adequately by the prison health service. Such cases should be used to analyze the way in which protection systems against torture and ill-treatment as well as the health system in the institution work, i.e. searching for the causes of such incidents and verifying whether they are casualties or part of a pattern. It needs to be stressed however, *that the primary purpose of monitoring health in a place of detention is a preventive one and medical examinations of prisoners are therefore done as the exception rather than the rule.*

2.2.2. Triangulation

Triangulation in the context of monitoring places of detention can best be defined as looking into more than two sources of information on the same issue and comparing the information obtained from these sources. It is a powerful technique that facilitates validation of the information obtained through cross-verification from two or more other sources, with the purpose of increasing the credibility and the validity of the results. Triangulation is very important in mon-

itoring places of detention, as one information source will almost never be able to provide the monitor with a complete picture of the situation. An example of triangulation making use of the health monitoring matrix is given in box 1.

BOX 1:

TRIANGULATION EXAMPLE – ACCESS TO HEALTH CARE SERVICES

A prison manager may inform the monitor that the institution has a prison health service in place which is highly accessible to all prisoners and with sufficient prison health staff to interview, examine and treat them timely and effectively and equivalent to what would have been the case in the community. However, when interviewing prisoners, the monitor hears a very different story. The prisoners state that accessing the prison health service is very difficult and most of prisoners' requests to see the doctor are being refused by the prison staff. They also tell that even when a prisoner gets his/her request accepted, he or she will usually have to wait at least a week before he/she can see the doctor, because the doctor is only in the institution for a few hours each week. They are also not satisfied with the access to treatment and say that they often do not get the treatment which they obtained in the community before their imprisonment. When interviewing prison guards, they state that all prisoners who request to be seen by a doctor get the permission to do so. When interviewing prison health staff, they state that there is a serious problem in the prison health clinic in terms of lack of resources, including time, equipment and possibilities to refer a prisoner to specialist treatment. They also indicate that prison guards take too much responsibility in filtering prisoners' requests to see the doctor.

Health monitor- ing matrix

Sources of information

	Prisoners	Health staff	Prison staff	Prison man- agement	Observations	Documents		
						Individual case records	Registers	Written instructions
Access to health services	Poor access to health care services: Requests filtered by prison guards and often not leading to access to the doctor Long waiting times No access to treatment equivalent to that in the community	Poor access to specialized treatment Lack of resources Prison staff filtering prisoners' requests to see a doctor	All prisoners who request access to a doctor get access	Good access to health care services and treatments for all				

(continues)

A monitor should carefully assess such situation and the discrepancies in information given by the various sources of information. He/she could summarize the information obtained from the different sources of information in the health monitoring matrix. It is clear that multiple sources should be consulted to get a complete picture of the situation. He/she should ask to get insight into documents, including medical records and any patient registries available (access to these may – depending on the monitors' mandate - require a particular permission and the informed consent by the prisoner). Throughout the monitoring visit, the monitor should use his/her observation skills and look for signs indicating the (lack of) accessibility to the prison health services and to different medications and treatment options. Only when using the full set of information sources available, the monitor will be able to get an as complete as possible picture of the actual situation, and hopefully a good indication of the 'truth'.

As demonstrated in the example in box 1, the information from different sources is often in contradiction with each other, which may be due to different levels of involvement in the specific issue investigated. However, it is important to realize that potentially all persons being interviewed may have a personal interest in the issues raised during an interview and replies may consequently be subject to manipulation. In the assessment of the validity of information from the different sources and in the process of triangulation, the monitors' own observations and the statements from those who are closest to the issue in question, should be given the highest value.

Monitors should realize in the dialogue and data collection from all involved actors – prisoners, prison management, prison guards, and prison health staff – that all actors may have their own agenda and may only be willing to reveal part of what they see as the truth. All may be under certain pressures, which may influence the way they are fulfilling their duties. Monitors should intend to look behind the façade trying to figure out the realities and assist all in the common objective, i.e. to ensure the dignity of prisoners and conditions and treatments in accordance with national and international standards.

The sequence of looking into the different sources of information is often not within influence of the monitor. However, most monitoring visits start and end with a talk with the prison management, which will give the monitor the opportunity to ask some basic questions at the start and discuss some of the information obtained during the time in the institution (in a confidential way) with the prison management at the end of the visit.

In many countries, international organizations like the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and the International Committee of the Red Cross (ICRC) are present and involved in for instance fighting Tuberculosis (TB), HIV/AIDS and other infectious diseases in places of detention. Hence, the monitoring team may have the possibility to seek advice from experts in the interpretation of findings and may have the possibility to recommend authorities to establish cooperation with such experts.

2.2.3 Interviewing for monitoring purposes

During a monitoring visit, a health professional will conduct interviews with at least the following groups of persons:

1. Prisoners
2. Prison management
3. Prison health staff
4. Prison guards and other prison staff

It is of key importance that interviews are always conducted in a peaceful and respectful manner. Ethical guidelines should be followed so that interviews will be conducted in the safest way possible for all involved and, in a way, as to minimize any negative consequences or risks for reprisals afterwards ('do no harm'). The ethical principles for medical research involving human subjects as published by the World Medical Association (WMA) in its Declaration of Helsinki are a good reference point for ethical guidelines to be kept in mind when conducting monitoring visits.¹⁴

Two ethical principles that apply to the monitor and should always be kept in mind, are:

- Do no harm: Always be aware that practically every monitoring activity may lead to reprisals towards any person who gave information to the monitor.
- Independence: Persons who have family members employed in the institution, relatives imprisoned or financial interests in the prison management should never take part in the monitoring of that institution.

During the monitoring visit, priority should be given to interviews taking place in private, i.e. out of hearing, and if possible, out of sight of staff members and fellow prisoners, and out of the range of surveillance cameras and microphones. This especially applies to interviewing prisoners. However, monitors should realize that all kinds of information spread rapidly within a place of detention. The fact that an interview has taken place will very soon be known by everybody interested. One way of mitigating the risk to individual interviewees is to interview many prisoners to minimize the risk that one particular prisoner is identified as the source of information.

Monitors should always aim to dress neutral, without any connotations of personal opinion, position, stance, sexual orientation or appeal. An identification card worn in a visible manner indicating the name of the monitor and the organization to which he/she is affiliated may be preferable.

In case individual interviews are not possible for some reason, such as lack of private space, conducting focus group discussions could be considered. Conducting group interviews requires specific safety considerations. In all settings of closed institutions, it must be considered that groups of individuals are very different as to backgrounds, personalities and interests.

It is important to be aware that in repressive regimes and institutions, authorities may for instance have informers among prisoners. Thus, the scope of a group interview with prisoners should only be about objective issues that could also be detected by the monitors without interviewing prisoners, e.g. physical conditions in the institution, access to work and education and physical exercise, quality of food. The group interview should be steered by the monitors in order to avoid issues that could implicate individual participants into a conflict with authorities or their fellow prisoners, based on personal observations or opinions. If this happens, in spite of attempts to prevent it, the group interview must be stopped immediately, and risks must be minimized.

A monitor should always think about his/her own safety and security when monitoring a place of detention. He/she should prior to the visit assess the different safety and security risks and decide on how to mitigate those risks. Ignoring risks may jeopardize the relations between monitors and the management, the staff members and the prisoners and have negative consequences for the objective of the visit and its follow-up.

14 WMA (1974, last amended 2013). *WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects*. World Medical Association, 2013. Available at: <http://www.wma.net/en/30publications/10policies/b3/>

When conducting an interview for monitoring purposes, an interviewer should always consider three basic questions:

- Does the interviewee understand the question?
- Is the interviewee able and in the possession of the necessary information to answer?
- Is the interviewee likely to be willing to answer honestly without manipulation of facts?
- Does the interviewee put him/herself at any risk by answering the question?

Formalities

Interviewees should always be informed about the purpose of the monitoring visit and the risks that may arise for them because of participating in an interview. Risks for prisoners include for instance the risk for reprisals by the prison authorities or fellow prisoners, which the person should be well informed about. The purpose of the visit is to ensure decent conditions and treatment in accordance with national and international standards and not to assist individual prisoners, which should be made clear by the monitor. Moreover, the monitor should inform the interviewee about the time available for the interview.

Gaining confidence and mutual respect

At the start of the interview, the monitor should clearly introduce him or herself and inform the interviewee about the purpose of the visit and the interview. The purpose and procedures of monitoring should be explained, *i.e. to ensure decent conditions and treatment in accordance with national and international standards, by means of collecting information via interviews and observations, analyses of the information obtained, followed by a dialogue with authorities about encountered problems and their possible solutions (making recommendations)*. Some internationally authorized visiting bodies distribute information sheets to staff members and prisoners, describing the procedures and aims of the monitoring visit. In the sheets, it is underlined that reprisals for having given information to monitors are against international law. In case such thing happens, persons are invited to report to a focal point and a phone number and e-mail address are included. Such an approach by the monitoring body of course relies on the acceptance of the authorities and the existence of a power to intervene whenever appropriate.

In case of interviewing a prisoner, the monitor should make very clear what he/she can and cannot do. A monitor should never make promises he/she cannot hold. The monitor should let the interviewee know that his/her observations and opinions are important for the objectives of the monitoring visit.

The attitude of the interviewer should be one of respect for the integrity of the person interviewed. If the interviewee does not want to touch certain issues, this must be respected. The interviewer should on the one hand show willingness to try to understand the situation and opinion of the prisoners, *i.e.* showing empathy, and should on the other hand be careful as to showing personal feelings and opinions, *i.e.* maintaining a certain professional distance.

In order to gain the respect of the interviewee, the monitor should appear well-informed about the generalities of the place of detention and the health services in the country as well as the particularities of the place visited. Some information given during an interview may be surprising. The monitor should avoid appearing naïve and maintain a professional attitude by asking clarifying questions. The monitor should maintain the privacy of the interview setting in case of interference by staff members or others. When interviewing a prisoner, inquiries about the criminal guilt of the person should in general be avoided as this information is irrelevant. Whatever crime a person may have committed, decent conditions and treatment must exist.

The gender of the monitor may be important to some prisoners. Especially women prisoners with a history of sexual abuse may only want to talk to a female monitor. The monitoring team should always respect such requirements and try to meet them as far as possible.

Below follows a brief description of the particularities that need to be taken into account when interviewing the four different groups of informants for monitoring purposes. Most of the information given in this chapter is relevant for any detention monitor, regardless of him or her being a health monitor.

In the part on interviewing prisoners, specific reference is made to certain groups of prisoners which are recommended to be interviewed by, or at least with the presence of, the health professional in the monitoring team.

Ad 1. Prisoners

Interviewing prisoners forms the basis of the process of obtaining information and documenting conditions and treatments in a place of detention. The viewpoints and stories of people residing in the institution on a daily base are key in any monitoring visit.

An interview with a prisoner must always be initiated with a presentation of the interviewer and an explanation of the purpose and outline of the interview. The monitor should explicitly ask the interviewee whether he/she wishes to participate, i.e. the **first informed consent**.

A monitor should aim for achieving a good balance between obtaining the information needed and making the interviewee feel confident, safe (what are the risks of non-intentional harm?) and secure (prevent reprisals from prison staff members or fellow prisoners) in talking to the monitor and having the opportunity to express his or her own observations, assessments, pre-occupations and feelings. The communication style of the monitor is important and should be as transparent, open, friendly and flexible as possible. The monitor should be able to understand and tolerate expressions and signs of distress, mistrust, reluctance, hostility or fear.

It may be deemed very relevant to use personal information from the interview in cases where prisoners describe a situation of ill-treatment or torture to the monitor. However, often the prisoners do not want their story to be reported or communicated to others due to fear of reprisals by the prison authorities or fellow prisoners. If, at the end of the interview, it appears to the interviewer that it could be valuable to document or in any other way hand-over specific information obtained during the interview, he/she must ask for permission. This **second informed consent** for using the information provided must always be obtained. As a general rule, no personal details, including any information that could identify the interviewed person, may be published or handed over to anybody outside the monitoring team without the expressed consent of the interviewed person. In addition to informed consents, the monitoring team should endeavor to ensure that publishing or handing over information from interviews does not expose the interviewed person to any risk of reprisals. Hence, it may happen that personal information cannot be released for security reasons, in spite of having obtained the required second informed consent. On the other hand, it may also happen that the monitor will have to release personal information to the prison health staff, even when informed consent is not obtained, in case this is in the clear interest of the interviewee for urgent health reasons (e.g. serious risk of committing suicide).

The location of the interview is important and any location which - in the perception of the prisoner - connects the monitor with the prison authorities (such as the office of the prison manager) should be avoided. A location out of hearing and sight of the prison staff members should be aimed for, but sometimes it is not possible to hold the interviews out of their sight. In a place of

detention rumors and information run fast, i.e. if a person is interviewed by monitors it will soon be known by everybody. Hence, keeping an interview out of hearing of other persons is essential and keeping it out of sight of others may further increase the comfort of the person interviewed. Monitors should always critically assess the situation and the possibilities available to them.

A monitor should take care to not just interview prisoners who asked for this themselves or who are proposed by the prison management or staff members. Instead, the monitor should aim for a broad sample of the total prison population in the institution. Often, a person may be shy and secluded because of oppression from staff members and/or fellow prisoners, i.e. representing those who can give firsthand information on the issues that are most important for the monitors. It is very important for a monitor to gain the confidence of the interviewee. Moreover, the monitor should at all times aim to protect the interviewee as much as possible. This includes interviewing many prisoners to increase chances that information obtained cannot be traced back to an individual prisoner, who may consequently be at risk of reprisals.

Interviewing specific groups of prisoners

Specific considerations apply when interviewing specific groups of prisoners, which are recommended to be interviewed by, or at least with the presence of, the health professional in the monitoring team.

Prisoners who (likely) suffer from a mental disorder, including symptoms of depression

Prisoners with a mental disorder may react in an unexpected manner during an interview. They may appear confused, afraid, unfocussed, angry, sad or helpless, to a higher degree than prisoners without a mental health problem. A monitor should always assess the situation carefully and only proceed with the interview if this is acceptable and does not create a harmful or dangerous situation, either to the prisoner or to the monitor him/herself. Especially when interviewing prisoners with a mental health problem, the monitor needs to make sure to close the interview properly, which means leaving the prisoner in a situation where he or she is ok to be left.

In general, monitors without experience in dealing with persons with a mental disorder and without knowledge about psychiatric issues should not address this group of persons.

Depression is an illness that involves the body, mood, and thoughts of a person and that affects the way in which that person eats, sleeps, feels about himself or herself, and thinks about life and other persons. When interviewing a person with a depression, the monitor should make sure not to make the interviewee's feelings of depression, despair and sadness worse. It is advised to keep the conversation as 'light' as possible e.g. not going into details about feelings, but focusing on conditions in the prison, daily life activities, relations to fellow prisoners and staff, and treatment offered for the depression. In case a monitor feels that the interviewee is at risk of self-harming or committing suicide anytime soon, the monitoring team should consider reporting to the head of the prison health service and/or the prison director in order to initiate psychiatric treatment and ensure conditions preventing the actual occurrence of the event. Informed consent for this should be sought; but even without consent the health professional on the monitoring team may consider reporting the case.

Prisoners who likely suffer from PTSD

Prisoners are more likely than people in the general community to suffer from Post-Traumatic Stress Disorder (PTSD).¹⁵ Prisoners who have experienced a shocking, scary or dangerous

15 Baranyi et al. (2017). Prevalence of Posttraumatic Stress Disorder in Prisoners. *Epidemiologic Reviews*. Vol.40, 2018. Available at: <https://academic.oup.com/epirev/article/40/1/134/4955401>

event, with torture as an obvious example, are very prone to have developed PTSD. The symptoms of PTSD are outlined in more detail in the chapter on mental health problems in Section 5.

When interviewing a prisoner with PTSD, it is even more important than usually that a monitor tries to establish an as good as possible atmosphere and conversation, makes sure to listen and observe carefully, and is aware of his/her own body language and way of talking. He/she needs to make sure not to go too far into the details of the traumatizing event in order not to be invasive or cause re-traumatization. During the interview, the monitor should be guided by the reactions of the traumatized person and give him or her the option to stop the interview at any time in case it becomes too much for him/her. The person that guides the speed and depth of the interview should be the interviewee with PTSD, not the monitor. Hence, the monitor needs to make sure to have enough time available before starting the interview in the first place.

When interviewing a prisoner with PTSD, a monitor should always make sure to close the interview properly and leave the prisoner in a situation where he or she is ok to be left. Follow-up questions to the interviewee may be needed, such as 'Would you like me to notify the prison health staff or to directly ask the psychologist or psychiatrist to come and talk to you later?'. The monitoring team may also consider if a transfer of the person to another ward or section of the prison could be an opportunity to mitigate continuous stress for the person. If the answer is thought to be yes, this should be openly discussed with the prisoner, as to whether the team should address the question to the prison management with the informed consent by the prisoner.

Prisoners with aggressive behavior

Some prisoners may be prone to reacting aggressively to a situation they do not like or cannot control, having a poor impulse control. Preventing anger from escalating into violence is very important during an interview. A positive assertive presence and being particularly careful in explaining the aim and procedures of the interview can help reduce anger escalation in a tense situation. Being neither aggressive nor servile in responding to an angry person has been shown to assist in keeping a situation from getting out of hand.¹⁶ A monitor should continuously assess the situation and only proceed with the interview if he/she thinks this is acceptable and does not create a harmful or dangerous situation, either to the prisoner or to him/herself. A possible point of departure may be to ask the person about the reason for the anger, underlining the monitor's need to understand and his/her neutrality. In case of doubt whether possible reactions from the person can or cannot be controlled, the monitor should refrain from interviewing. A violent episode may jeopardize the whole monitoring visit.

Prison authorities sometimes advise monitors against interviewing certain (groups of) prisoners or even prohibit interviews referring to the prisoners' aggressiveness or dangerousness. Sometimes this is a pretext to avoid that torture and ill-treatment become revealed to the visiting team. Monitors should of course listen to the authorities, but should also be critical and make their own choices based on observations and an initial presentation/conversation with the prisoner (possibly through bars). In such cases the monitor should be flexible and diplomatic, not creating conflicts with staff members and remembering that the ultimate responsibility for their own security relies on themselves and that a violent episode may jeopardize the whole visit. Before commencing an interview in private, such risk must be carefully appraised by the monitor. The confidence between the interviewer and the prisoner should be mutual and if the interviewer feels unsafe in the company of a prisoner it would jeopardize the perceived validity of the information gained.

16 See [Correctionalnurse.net: http://correctionalnurse.net/how-to-deal-with-inmate-anger/](http://correctionalnurse.net/how-to-deal-with-inmate-anger/)

Prisoners infected with Tuberculosis (TB) and other communicable diseases

When interviewing a prisoner with TB, a monitor needs to be careful and protect him/herself in all possible ways in order to avoid getting infected. Wearing protective mouth masks is highly necessary when entering a ward where prisoners infected with TB are accommodated. The regulations existing in the institution must always be complied with. In any case, when dealing with patients with a transmissible disease, a scrupulous hand hygiene is mandatory, e.g. using own disinfectants after each encounter with patients.

A monitor should always respect the interviewee and should not go too much into the interviewee's feelings about his/her disease status unless the prisoner clearly is ok and comfortable with talking about it. However, if the monitor gets the impression that the medical treatment is inadequate, he or she should request the permission of the prisoner to study the medical record and subsequently report back his/her assessment. If it is hereafter believed that the treatment is inferior to the treatment standards in the country, this should – with the consent of the prisoner – be discussed with the prison authorities. A case of inadequate treatment should be analyzed as to whether it is an exception/mishap or an indication of a deficient system of care for such patients. This may necessitate that some more similar cases are assessed. The right to the best attainable health for a prisoner is equal to that of any other citizen in the country and is a foundation for monitoring health in prisons.

Prisoners with a substance use disorder

When interviewing a prisoner with a current and/or past substance use disorder, a monitor should be aware of the possible effect of the dependency and/or likely withdrawal symptoms on the prisoner's mental health status and his or her ability to be focused and clearly express him/herself during the interview. The monitor should keep in mind that the prisoner may not be honest about his/her past and/or current substance use, as the substance is not allowed within the institution. The monitor should ask about the treatment and support options available to the prisoner. He/she should also be aware that active substance use in prison often implies tense relations to other prisoners due to debts and a need to smuggle drugs into the prison. This creates an association between substance use and inter-prisoner violence (see also the respective chapters on substance use disorders and violence in Section 5).

Prisoners who have been victims of torture and/or ill-treatment

Interviewing persons who allege to be a victim of torture and/or ill-treatment is an extremely sensitive process. It requires particular care and interviewing skills.

The Istanbul Protocol - Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment is the gold standard for guidance on how to investigate and document cases of torture and ill-treatment.¹⁷ It includes a section on interviewing alleged victims and other witnesses with important considerations, most of which are relevant for monitors as well. It stresses the importance of open and non-leading questions and allowing the person to tell his or her own story. Considering the nature of torture cases and the trauma that a person suffers as a consequence, it is particularly important to show sensitivity to the alleged torture victim. The person always has the right to refuse talking about the incident or withdraw from the interview. As cannot be stressed enough, alleged victims of torture should always give their informed consent before any further action regarding their case is being initiated, including addressing the prison authorities or complaint mechanisms.

¹⁷ UN (2004). *The Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment*. Office of the UN High Commissioner for Human Rights. Available at: <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

Whenever possible, the monitor should ask the prisoner for physical evidence of the torture and conduct basic documentation if the prisoner gives his/her informed consent to do so. The role of the medical professional in the monitoring team becomes very clear in this regard.

It is important to note that, most often, visible physical marks after torture heal in a short period of time, often weeks. In the case of volatile marks, such as bruises, it may be of paramount importance to the future justice process that these are documented, ideally by forensic photographing, while they are still present. Invisible physical symptoms, such as soft tissue pain may last much longer but are more difficult to document objectively. Assessing the body functions, including the gait and ranges of joint movements, may give valuable information. Psychological effects of torture, prevalent in most persons who have experienced torture, are even more difficult to document, are detrimental for the victim and require different skills of the examiner and sufficient time to shed light on. The monitoring team should consider the possibility that one or a few of its members (including medical professionals) have specialized training and are the ones who conduct such interviews.

More guidance on how to follow up on prisoners who allege to be a victim of torture or ill-treatment can be found in chapter 2.3. on follow-up on the monitoring visit. More on monitoring torture in general can be found in Section 6 of this manual.

Ad. 2 Prison management

Interviews with prison management usually take place at the start and at the end of a monitoring visit. Sometimes, the monitor is accompanied by a member of the prison management during the course of the monitoring.

The meetings with the prison management usually take place in the office of the prison manager or in a meeting room. It is important for a monitoring team to always show respect for the prison management and thank the prison manager for his/her hospitality and the opportunity he/she provides to monitor the place of detention.

A certain professional distance to prison management is however vital, in order not to be seen as 'one of them' by the prisoners and by other staff members in the place of detention. Often the first thing after the initial meeting with the prison management is a round through all prison facilities. It may be considered to leave this round to the leader of the monitoring team and let other members start working in the facilities in order to save time and to avoid the risk that prisoners might think that the visitors are not neutral and not independent from the authorities. Subsequently, there could be a debriefing among all members to assess whether information acquired should lead to a change in the priorities of the planned programme. It is important to always assess the information gotten by the prison management with objectivity and care. A monitor should aim to be kind and respectful and to show understanding of the challenges the prison management faces in this institution. Blaming and shaming is in nobody's interest and will often do no good for the monitors' aim to achieve conditions and treatments in the place of detention which are (better) in line with international human rights standards. The best scenario could be that the management sees the monitors as allies in the work for better conditions for prisoners. Well-founded recommendations for changes are then seen as needed arguments from outside the prison system to convince higher authorities and politicians that some changes in the daily administration of prisons would be in the best interest of all. This would lead to improved conditions and a more humane treatment with lower levels of frustrations and violence inside the institution, which is the basis for a better re-socialization and subsequently lower rates of recidivism after release.

At the final meeting with prison management, the monitor should raise some general observations and impressions as obtained during the visit. Some basic recommendations may be given, preceding the more elaborated recommendations as will be included in the report of the monitoring visit. At all times, the monitor needs to be careful not to go in too much detail about sensitive cases and not to mention cases nor names where the prisoner has not explicitly given his/her informed consent for sharing the story.

Ad 3. Prison health staff

The health monitor needs to ensure that a visit to the prison health clinic and interviews with prison health staff, including the prison doctor whenever possible, are included in the monitoring visit. Prison health staff will be able to give the monitor information about the organization of the health care services, the contacts of the prison health clinic with the health care services (including specialized health care services) in the community, the most prevalent health problems among the prisoners in the institution, and the main challenges with regard to their work and within the institution.

When interviewing prison health staff, it is important to know to whom they report. In most countries, prison health staff are employed by the prison authorities and therefore report to them. This implies several dual obligation issues, which are discussed in detail in the respective chapter in Section 3. In some countries, the prison health staff report to the Ministry of Health, similar to the way in which the health services in the community are organized. In this case, the prison health staff may still face dual obligation issues, however, they may feel more willing to talk openly about the challenges within the prison health service and their relationship with the prison authorities.

The monitor should always respect the position of the prison doctor and other prison health staff. In most cases prison health professionals are very helpful and willing to give the monitor all the information requested - especially when he/she is a health professional as well. Like with all other interviews, it is not the objective of the interview to express the monitor's opinion; the objective is to receive relevant information on all health aspects in the place of detention.

The (few) prison health staff are key informants and going through the many relevant issues will often take hours. Therefore, as far as possible, it should be ensured that the visit is scheduled for a date on which they are present and available for a lengthy interview.

Ad. 4 Prison guards and other prison staff

Interviewing prison staff members includes interviews with prison guards, security officers and other staff working in and around the place of detention, such as teachers, the priest social workers etc. (health staff excluded). Interviews with prison staff are important to include in any monitoring visit, because the staff members are in frequent contact with the prisoners. They often know very well the situation and the conditions in the institution, including the main challenges. When interviewing prison staff, it is important to understand their position within the place of detention and their line of command towards the prison management. A monitor should aim to avoid bringing prison staff in a difficult position by asking about the performance of the prison management. Prison staff should be approached with respect and appreciation for their work and interviews should preferably be individualized and take place in a place where confidentiality can be upheld without bringing the interviewee at risk.

In some prisons the "culture" of guards is problematic; it may be dominated by strong individuals who benefit from corruption and drug trade. Colleagues who do not want to adhere, may be subject to reprisals and oppression. Revealing such problems is very relevant for the monitors,

but they must be extremely careful to protect the identity of informants. Interviewing many staff members is a means to blur sources of information. At the same time, it gives a better possibility to discover true facts.

Prison guards are often those who collect prisoners' requests for a medical consultation, and, in some instances, are also those who are in charge of handling medicines prescribed by the prison doctor. This gives them a professional competence beyond their training/capacity, and it places them into a position of power that may be abused. This is something a health monitor should be highly aware of and monitor closely by means of triangulation. More on these issues can be found in the chapters on access to health care and handling of medicines in Section 3.

Interviews with *prison guards* will be the primary focus throughout this manual, when referring to interviews with prison staff.

Further reading

APT (2004). *Monitoring places of detention. A practical guide*. Association for the Prevention of Torture, Geneva, April 2004. Available at: https://www.apr.ch/content/files_res/monitoring-guide-en.pdf

DCI (2016). *Monitoring places where children are deprived of liberty. Practical guide*. Defence for Children International, Belgium. Available at: <https://defenceforchildren.org/wp-content/uploads/2016/02/DCI-Practical-GuideEN.pdf>

UN (2004). The Istanbul Protocol. *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment*. Office of the UN High Commissioner for Human Rights, 2004. Available at: <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

WHO (2003). *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*. World Health Organization, Geneva, 2003. Available at: www.who.int/gender/documents/en/final%20recommendations%2023%20oct.pdf

WMA (1974, last amended 2013). *WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects*. World Medical Association, 2013. Available at: <http://www.wma.net/en/30publications/10policies/b3/>

2.2.4. The use of numbers in monitoring health in places of detention

Epidemiology is defined by the World Health Organization as '*the study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other health problems*'.¹⁸

In other words, this means that epidemiological methods can be used for analyzing numbers and using them as the basis for studying, for example, how many cases of a certain diseases are seen in a particular institution, for assessing whether the number of cases is high in comparison with other institutions, and for assessing the development over time. More complicated statistics can also be applied, for example if you would like to assess whether a certain factor influences the occurrence of a certain situation or condition. For example, are prisoners more

18 See WHO website: <http://www.who.int/topics/epidemiology/en/>

prone to attempting suicide if they have just received their sentence or if they have a substance use problem? Such more complicated calculations are often done in research but are not the focus of this chapter. This chapter focusses on how numbers can be used to assess the health status of a prison population through relatively simple calculations.

Epidemiology (and quantitative methods in general) is seldom used as a tool in monitoring places of detention, although it can lead to important insights and would certainly contribute to a more comprehensive assessment of the place of detention and the health of the prisoners. As this manual emphasizes in Section 5 on monitoring prisoners' health, prison populations constitute a vulnerable group with a poor overall health status compared to the general population.^{19 20} The use of epidemiology in health monitoring can provide a systematic insight into the health issues in a specific place of detention, which may be a prerequisite to prevent and address diseases, self-harm and suicides, violence, torture and ill-treatment as well as excess mortality among prisoners. These systematic insights can form a solid basis for health advocacy aimed at the prison administration as well as those responsible for national and international policies regarding prison health.

The use of epidemiology in monitoring health obviously requires that numbers on health-related states or events are available to the monitoring team. This is however not the case in all places of detention throughout the world. Ideally, the numbers should appear in the registers kept by the prison (health) service, which should be looked into in connection with the monitoring visit. If a monitoring team gives notice prior to visiting a place of detention, the monitoring team could also request to receive numbers on relevant health-related states or events before the visit. If the visit is without prior notice, a monitoring team can request to receive relevant numbers at the time of the visit or to have the relevant numbers sent to them afterwards.

A monitoring team might find that different time intervals are relevant for evaluating different health-related states or events, depending on, for instance, the rarity of the event, the incubation time and the contagiousness of a disease. Provided that data is available in the given place of detention, a monitor may request data on for instance an annual basis.

Examples of relevant data to request for data analysis and interpretation

For a monitoring team who applies an epidemiologic approach to monitoring health in a place of detention, it is useful, in general, to ask for data on the size of the prison population at the time of monitoring and on the average daily prison population within e.g. the last year. As will be seen later in this chapter, these numbers are used for different types of calculations that make it possible to make comparisons, e.g. between institutions and between prisoners and the general population.

The relevance of the different health-related states or events varies depending on the geographical area of the institution and the focus of the visit. In the chapters in this manual describing how to monitor a certain aspect of prison health, examples are given on how to use numbers when monitoring this particular aspect.

The following is a comprehensive description of the use of epidemiology in monitoring 1. self-harming and suicide, 2. communicable diseases including water and sanitation-related diseases, 3. violence, 4. torture and ill-treatment, 5. use of solitary confinement, and 6. deaths in

19 Fazel, S., & Baillargeon, J. (2011). The health of prisoners. *The Lancet*, 377(9769), 956–965. Available at: [https://doi.org/10.1016/S0140-6736\(10\)61053-7](https://doi.org/10.1016/S0140-6736(10)61053-7)

20 WHO Regional Office for Europe. (2014). *Prisons and Health*. Copenhagen, Denmark. Available at: www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

custody. These examples have been selected as they are especially in line with the aim of this manual, i.e. to prevent torture and ill-treatment, and thus the use of epidemiology in this regard is intended as an inspiration for a monitoring team.

Self-harming and suicide

An epidemiologic approach to monitoring self-harm and suicide in a place of detention includes, but is not limited to, requesting and interpreting data on the number of cases of self-harm and suicides within, for instance, the past year. Based on these numbers, a monitoring team could estimate incidence and incidence rates and compare these estimates with those of previous years. Additionally, a monitoring team could quantify the use of preventative initiatives in the place of detention by e.g. requesting data on the proportion of prisoners screened for risk of self-harming and/or suicide upon their arrival in the institution.

The case in box 2 is an example of the use of epidemiology in health monitoring in Moroccan prisons, which revealed an increasing incidence of suicides, leading to the development/ implementation of a preventative initiative.

BOX 2:

THE USE OF EPIDEMIOLOGY IN MONITORING SUICIDES IN MOROCCAN PRISONS

Moroccan prison authorities collect mortality data regularly, and over the years they have found an average of 6 suicide cases per year. In 2015, however, Moroccan prison health services noticed a spike in the number of suicides in prisons, as the number of suicides had increased to 15 cases. While the incidence of suicides had obviously increased, it was only meaningful if they compared this to the prison population size, which they discovered had actually decreased slightly. The assessment of the increasing incidence rate of suicides led to the development of an intervention that commenced with country-wide data collection to better understand the magnitude, dynamics and reasons for this spike and how to reduce not only suicides, but also self-harm cases in Moroccan places of detention. Based on those findings, a national policy and clear guidelines for all prison staff on suicide and self-harm in prisons have been developed, along with capacity building in line with international standards and expertise.

Communicable diseases including water and sanitation-related diseases

In terms of using epidemiology in monitoring communicable diseases, including water and sanitation-related diseases, in places of detention, it may be relevant for a monitoring team to request data on the annual number of cases of illnesses associated with lack of access to clean water and sanitation facilities. This may include conditions such as hepatitis A, scabies, cholera and gastroenteritis. Based on these data, a monitoring team will be able to assess and interpret, for instance, incidence and incidence rates.

Likewise, it may be relevant for a monitoring team to request data on both the total number of prisoners diagnosed with communicable diseases such as tuberculosis, HIV, hepatitis A, B and C at the time of monitoring as well as the number of prisoners diagnosed with these diseases within the past year. Based on these data, a monitoring team will be able to assess and interpret prevalence proportions, incidence and incidence rates. Other relevant communicable diseases include influenza, respiratory diseases and sexually transmitted infections, and furthermore, diseases relevant to the geographical area of the place of detention such as parasite or vector borne diseases like malaria and dengue fever. For these latter conditions, it is mainly relevant to assess and interpret incidence and incidence rates because they are transient and not chronic in nature. Lastly, a monitoring team can quantify the use of preventative initiatives in the place

of detention by e.g. requesting data on the proportion of prisoners screened for communicable diseases upon their arrival.

Violence, torture and ill-treatment

A monitoring team could use epidemiology in monitoring health in a place of detention not only to assess morbidity and mortality, but also to assess incidents which amount to torture or ill-treatment. Relevant incidents for a monitoring team to assess include, for instance, the annual number of physical violence both among prisoners and between staff and prisoners, both staff-to-prisoner violence and prisoner-to-staff violence. Other relevant indicators of violence, torture or ill-treatment include the annual number of prisoners examined and treated in the place of detention for traumatic lesions, or the annual number of injuries, deaths and other health consequences due to misuse of physical restraint measures. In this regard, it is also relevant to assess the annual number of times force and physical restraint methods have been used towards prisoners by prison staff, e.g. the use of handcuffs and pepper spray.

Use of solitary confinement

Use of solitary confinement is a prison health factor, which is relevant for an epidemiologic approach to health monitoring, as it is linked with mental health problems and an elevated risk of self-harm and suicide. A monitoring team could request data on both the annual number of times solitary confinement is being used and admissions/referrals to the prison health services for psychiatric reasons in relation to solitary confinement. In this regard, it may also be relevant for a monitoring team to assess the incidence and prevalence of mental health problems, self-harm and suicide among (previously) isolated prisoners.

Deaths in custody

It is relevant for a monitoring team to request data on deaths in custody, as these might be a direct consequence of torture or ill-treatment, such as denial of prisoners' right to health and adequate health care. Besides requesting data on the annual number of deaths and estimating the crude mortality rate in a place of detention, a monitoring team should request data on all cases of death in custody and analyze them for manner of death, causes of death and circumstances – particularly with a view to whether the death was preventable. In case a death seems to have been preventable, the monitor should investigate what went wrong and the management's handling of the case, particularly with a view to prevent cases in the future. For instance, the monitor could analyze the annual number of deaths due to a specific communicable disease as well as the number of accidental or homicidal deaths, and hence estimate mortality rates for specific causes or manners.

Data analysis and interpretation

A health monitor could request to receive numbers on, for instance, tuberculosis, as a high prevalence of tuberculosis in a place of detention may be an indicator of ill-treatment in terms of lack of access to adequate health care and/or lack of adequate infection control measures (see also the chapter on communicable diseases in Section 5).

Let us look at a concrete example:

*The prison population in nine county jails in São Paulo was examined for tuberculosis. Out of a total prison population of 1122 prisoners, 1052 gave their consent to participate in the study, and among those, 21 cases of tuberculosis were found.*²¹

In other words, there was a prevalence of 21 in the prison at the time of the examination. However, are 21 cases of tuberculosis many? What if there were 50 cases in jails in another city, would that then automatically mean that the risk of having tuberculosis was more than double there?

In order to answer those questions, it would be necessary to not only look at the absolute numbers but to also take into account the number of prisoners in the two locations. If the prison population in the other city was more than double, the numbers might not be very concerning, because the *proportion* of cases would still be the same. But, if on the other hand, the 50 cases occurred in a prison population that was smaller than the one in São Paulo, the numbers would give rise to worry.

In the example, the proportion of prisoners with tuberculosis was 21 out of 1052 or in other words 2%. This percentage may not in itself say much, but what the investigators then did was compare that number not with a neighboring jail but with how frequently tuberculosis was found in the general population. And there, the result was alarming: The proportion of infected prisoners was 70 times as high as in the general population! It was also found that 6 of the 21 cases came from the same jail and that the risk of acquiring tuberculosis was particularly high in that jail.

This example shows how you can draw some very important conclusions, even with very little data, especially if you compare prison data with data from the general population in the same country. If such data is not available, one can also turn to data that has been published elsewhere, for example in scientific literature. For instance, a meta-analysis of studies published between 2005 and 2015 outlined that prevalence of tuberculosis in prisoners was found to be 5% in Eastern and Southern Africa, 3% in West and Central Africa, 5% in Eastern Europe and Central Asia, 2% in Latin America, 1% in Asia Pacific, 0,5% in Middle East and North Africa, and 3,5% in North America.²² Comparing the data from the São Paulo jail will then show us that the numbers found are actually very much in line with other Latin American experience. This, however, should never lead the prison monitor to inaction since the risk of having tuberculosis if someone is inside the prison is still substantially higher than outside.

Based on the above, you will see that it is important to remember that absolute numbers can only be compared directly if the numbers come from populations that are comparable in terms of size. Otherwise, you need to calculate before making the comparison. In epidemiological terms, technically what was done in the example above was to calculate and compare what is called *prevalence proportions*. For further details on this, see textbox at the end of the text.

Estimating the prevalence proportion is a useful way of looking at a disease pattern at any given point in time. However, it does not provide information about the occurrence of new cases over time. It may therefore be necessary to look at other measures as well. The importance of doing so becomes particularly important when looking at diseases that are easily curable or self-limiting or fatal within a short period of time, because the prevalence may be low or even nil

21 Abrahão, Nogueira, Malucelli (2006). Tuberculosis in county jail prisoners in the western sector of the city of São Paulo, Brazil. *Int J Tuberc Lung Dis* 10(2):203–208. Available for download at: <https://www.ingentaconnect.com/content/iuatld/ijtld/2006/00000010/00000002/art00016?jsessionid=wlb8t4vvp3h.x-ic-live-02#>

22 Dolan et al. (2016). Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *Lancet*. 2016 Sep 10;388(10049):1089–1102. Available at: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30466-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30466-4/fulltext)

at a given point in time just because, by coincidence on that particular day, no one happens to be sick, even though the burden of disease is generally high.

If again taking tuberculosis as point of departure, the monitoring team in the example above could also have decided to look at the number of new cases within a specific period of time. This is called the *incidence*. If, for example, there are 9 new cases over the last year, the yearly incidence would be 9. Here again, however, we would need to take into account the size of the prison population if we want to make comparisons with other institutions or with the general population. This is done by calculating what is called an *incidence rate* that indicates the intensity at which new cases of a disease occur in relation to the total number of people in the given population.

The incidence rate could then be compared with the rate in other populations to estimate whether there are more new cases over a certain time period inside the prison than outside. The importance for the monitor of assessing incidence of a disease in the institution lies in the fact that getting infected with a disease in an institution may amount to ill-treatment. A person is punished to a sentence and not to a disease (see also the chapter on communicable diseases in Section 5).

Another type of information from analyzing incidence data comes from looking at the new cases and trying to assess whether a disease has been acquired inside the prison or was brought with the prisoner to the prison after having been acquired elsewhere. When monitoring, this is an important assessment to make, because acquiring a serious preventable disease while in prison may be a violation of standards. When making this assessment, one needs to take into account the incubation time, i.e. the time elapsed between exposure to a pathogenic organism (or a toxic substance or radiation), and when symptoms and signs are first apparent. If the symptoms and signs develop after a time period in prison longer than the known incubation time, it is safe to conclude that the disease has been acquired in the prison. For some diseases, this type of assessment is easily done, because the incubation time is well-known, whereas for others including tuberculosis it may be more complicated because the disease may lie dormant in the body for a long time before giving rise to symptoms. In that case, further analysis needs to be made.

In the abovementioned example on tuberculosis, an assessment was made of the relation between length of incarceration and the risk of carrying tuberculosis bacteria and other related bacteria. The conclusion was that the risk increased with length of incarceration and that recidivists had a higher risk of being infected than first-time offenders. This supports the assumption that the transmission of disease actually took place within the jails.

In order to discover trends, a monitoring team could also evaluate numbers over the past years compared to current estimated incidence rates. Thus, in order to discover trends within a place of detention, a monitoring team must request to receive numbers from the previous years, and moreover, advocate for a continuous data collection in the place of detention.

Besides requesting data about frequency of diseases, a monitoring team can also request data on deaths in a place of detention and hence assess the mortality. Assessing these data can be done using the same types of calculations as mentioned above looking at deaths as incidents and calculating death rates (also called mortality rates) that can then be compared with death rates in other populations or institutions. Such death rates are often called *crude mortality rates* where the word “crude” implies that comparisons cannot necessarily be made without additional calculations to adjust for differences in the populations compared. To do so requires complicated calculations and will not be dealt with further here.

A monitor might also be interested in looking further into the actual composition of the mortality in a place of detention, i.e. which conditions contribute to the mortality. This can be done by calculating the *proportional mortality rate* for the different causes, i.e. the percentage assigned to each cause of death. It may also be relevant to look at the risk of dying if you acquire a certain disease inside the prison as compared to outside. This is called the *case fatality rate* and is relevant to the monitor because it may give indications as to whether the health care in the prison is adequate or not. E.g., if no proper screening takes place, diseases may be discovered too late to be curable, and if the treatment provided is sub-standard it may lead to higher mortality.

Cautions when analyzing prison health data

Even when comparing data as indicated above, where the differences in size between populations are taken into account, one still needs to be careful because prison populations differ from the general population regarding many aspects of health and demographics. For example, prison populations are generally younger compared to the general population, which can be reflected in different patterns of diseases and mortality. Also, the proportion of men in the prison population is significantly higher than the proportion of women. Statistically, it is possible to adjust for age, sex and other characteristics that differ between populations. It is also possible to analyze trends over time and to compare different groups in more detail than what is described above. It goes beyond the scope of this chapter to explain this methodology in detail, and readers are referred to epidemiology textbooks for further details.

Another aspect to take into account is the phenomenon called statistical significance. In technical terms, when something is statistically significant it means that e.g. a difference seen between two populations (or within the same population at two different points in time) is most likely not attributed to chance. In other words, there is a *real* difference between the two populations. Using statistical methods, it is possible to calculate to which degree it is likely that a difference found between two populations is indeed a real difference or not. Again, it goes beyond the scope of this chapter to demonstrate this, but for a monitor it is important to understand that the smaller the groups and/or the smaller the differences, the more likely it is that the differences are due to chance only.

A monitor should also be aware of the impact of the varying access to and quality of the health services between prisons and reflect on the implications when analysing data. For instance, a prison with easy access to high-quality health care services may in fact be more likely to report high incidences of health-related states or events, because more cases are identified, diagnosed and/or treated, whereas in other institutions there may be under-reporting. Thus, the impression of the occurrence of diseases in the different places of detention might be misleading. Also, in a prison with poor or no initial medical assessment of prisoners upon arrival, the monitor should be careful when concluding that health conditions arising among inmates in the institution are in fact new health conditions, because they may have actually been there already but were missed on arrival and only diagnosed after some time.

In conclusion, numbers are a very useful tool for monitors who attempt to assess the health of the prisoners and the functioning of the prison health system, but care should be taken to not overinterpret the findings, and it may be necessary to seek advice from someone with statistical knowledge before drawing very firm conclusions.

BOX 3:**THE EPIDEMIOLOGICAL CONCEPTS USED IN THE TEXT**

Prevalence proportion =	$\frac{\text{Number of cases of a disease in a defined population at a specific point in time}}{\text{Number of people in the same population at the same point in time}}$
Incidence rate =	$\frac{\text{Number of deaths from all causes in a defined population within a specific period of time}}{\text{Number of people in the same population within the same period of time}}$
Crude mortality rate =	$\frac{\text{Number of cases of a disease in a defined population at a specific point in time}}{\text{Number of people in the same population at the same point in time}}$
Proportional mortality rate =	$\frac{\text{Number of deaths assigned to a specific cause in a defined population within a specific period of time}}{\text{Number of deaths from all causes in the same population within the same period of time}}$
Case fatality rate =	$\frac{\text{Number of deaths assigned to a specific disease in a defined population within a specific period of time}}{\text{Number of people diagnosed with the same disease in the same population within the same period of time}}$

Further reading

For more information on interpreting data and calculating rates, see 'Basic Epidemiology', a textbook by the WHO which covers the basic principles and methods of epidemiology. Available at: <https://apps.who.int/iris/handle/10665/43541>

For access to **data on prison systems around the world**, see the 'World Prison Brief' by the Institute for Criminal Policy Research (ICPR) at Birkbeck, University of London. Available at: <https://www.prisonstudies.org/world-prison-brief-data>

For access to data on health in prisons in countries in the WHO European Region, see the 'Health in Prisons European Database' by the WHO. Available at: [https://apps.who.int/gho/data/node.prison.All_Countries?lang=en](https://apps.who.int/gho/data/node/prisons.All_Countries?lang=en)

2.3. Follow-up on the monitoring visit

A monitoring visit should not be a stand-alone event but should be followed up on. The monitoring team has a key responsibility in following-up on the findings they encounter during the visit. These findings include health-related findings, such as those concerning the health services in the institution and the prison factors influencing health, but also findings related to allegations/suspicions of torture and/or ill-treatment.

As presented in Section 1.2., the monitoring cycle includes several elements of follow-up, i.e. validation of the findings, evaluation of the findings against standards, analysis of the findings, recommendations at the local or central level, and follow-up on recommendations (which may include a follow-up visit to the institution). During the meeting of the monitoring team after the visit, the task of the health monitor is not only to present the health-specific findings he/she came across during the monitoring visit, but also to point out the health-specific aspects in the general findings as presented by other team members.

Recommendations should be made to the prison management and prison health services on how to improve the current situation, practices and services provided. Recommendations on systematic issues (e.g. general policies and national guidelines) should in principle not be made to the institution, but instead to the superior prison authority/Ministry, while informing the institution. Recommendations should be formulated as specific, measurable, achievable, result-oriented and time-bound (SMART) as possible. The Association for the Prevention of Torture has in 2008 presented a *'Double-SMART recommendations model'* which defines criteria that can be systematically applied in order to make recommendations as effective and useful as possible. Double SMART refers to recommendations that should not only be specific, measurable, achievable, result-oriented and time-bound, but should also be solution-suggestive, mindful of prioritization, sequencing and risks, argued, root-cause responsive and targeted.²³ The model provides a good reference for the monitor when formulating recommendations.

Health-specific recommendations concern issues related to the prison health services, prison health factors or prisoners' health. Depending on the mandate of the monitoring team, the health monitor could also want to follow-up with the prison authorities and/or prison health services on individual cases he/she came across during the visit. In these cases, the monitor always needs to have the informed consent from the concerned prisoner. This is of key importance, as the prisoner needs to be aware of the consequences a follow-up may have for him/her, including the risks of reprisals by prison staff or fellow prisoners. Health-specific recommendations and follow-up on individual cases could for instance involve the transfer of a prisoner to another ward or ensuring that a prisoner gets access to a psychiatrist.

Recommendations, and the follow-up on these, should always be done under the mandate of the monitoring team as a whole, i.e. the health monitor should not follow-up on findings in his/her own capacity.

Besides following up with the institution, the health monitor could also consider to follow-up on the health-specific findings and recommendations with the national health authorities and/or, if appropriate in the respective country, with the national medical association. The WMA Resolution on the responsibility of physicians in the documentation and denunciation of acts of torture or cruel or inhuman or degrading treatment, explicitly recommends that national medical associations *'attempt to ensure that detainees or victims of torture or cruelty or mistreatment have*

23 APT (2008). *Detention Monitoring Briefings. Briefing No.1. Making effective recommendations*. Association for the Prevention of Torture, Geneva, 2008. Available at: https://www.apr.ch/content/files_res/Briefing1_en.pdf

access to immediate and independent health care,²⁴ stressing that national medical associations have an important role in this regard.

24 WMA (2003, rev. 2007). *WMA Resolution on the responsibility of physicians in the documentation and denunciation of acts of torture or cruel or inhuman or degrading treatment*. World Medical Association, 2017. Available at: <https://www.wma.net/policies-post/wma-resolution-on-the-responsibility-of-physicians-in-the-documentation-and-denunciation-of-acts-of-torture-or-cruel-or-inhuman-or-degrading-treatment/>

SECTION 3: MONITORING PRISON HEALTH SERVICES

3.1. Introduction

'The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status' (Mandela Rule 24)

The majority of places of detention around the world have some sort of health service in place, however the nature, quality and accessibility of these services vary widely. In some places, the health service may be limited to having a doctor in the community on call for emergencies, while in other places a comprehensive health service is present within the place of detention. Some prison administrations have their own prison hospital, so that for emergencies and more advanced medical treatments a prisoner will not have to leave the criminal justice system.

International standards and guidance

As outlined in several international standards and conventions, all prisoners are entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity and prisoners shall have access to health facilities, goods and services, without discrimination.²⁵

The Mandela Rules stress the necessity and requirements of a prison health service. For instance, Rule 25 states that *'every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation'*. In Rule 35, it is stressed that *'regardless of the circumstances, the ultimate goal of health care staff in prisons must always be the welfare and dignity of the patients.'*

Prison health and public health should be closely linked, which is stated by several international organizations including the WHO Regional Office for Europe in its Moscow Declaration on Prison Health as part of Public Health.²⁶ The Declaration elaborates on some of the reasons why close working relationships between prison health and public health authorities are so important, including the following:

- Penitentiary populations contain an overrepresentation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions, drug users, vulnerable people and those who engage in risky activities such as injecting drugs and commercial sex work.
- The movement of people already infected or at high risk of disease into penitentiary institutions and back into the society without effective treatment and follow-up, gives rise to the risk of the spread of communicable diseases both within and beyond the penitentiary system. Prevention and treatment responses must be based on scientific evidence and on sound public health principles, with the involvement of the private sector, nongovernmental organizations and the affected population.

25 See for an overview: Lines R (2008). The right to health of prisoners in international human rights law. *International Journal of Prisoner Health*, March 2008; 4(1): 3-53.

26 WHO/Europe (2003). *Moscow Declaration Prison Health as part of Public Health*. World Health Organization Regional Office for Europe, Copenhagen, 2003. Available at: http://www.euro.who.int/__data/assets/pdf_file/0007/98971/E94242.pdf

- The living conditions in most prisons of the world are unhealthy. Overcrowding, violence, lack of light, fresh air and clean water, poor food and infection-spreading activities such as tattooing are common. Rates of infection with TB, HIV and hepatitis are much higher than in the general population.

The European Committee for the Prevention of Torture (CPT) has set out seven essential principles for the practice of prison health care, which will be addressed throughout the following chapters in this Section, i.e.:

- Access to a doctor, which will be addressed mainly in the chapters on access to health care and on the initial medical assessment in this Section.
- Equivalence of care, which will be addressed in the chapter on equivalence of care in this Section.
- Patient consent and confidentiality, which will be addressed in the chapters on informed consent and medical confidentiality in this Section.
- Preventive health care, which will be addressed mainly in the chapters on the role of the prison health professional and dual obligation dilemmas, and on health promotion and disease prevention in this Section.
- Humanitarian assistance, which refers primarily to marginalized and vulnerable populations and their special needs. This is mostly addressed in Section 5, in the chapters on special needs and on the specific needs of female prisoners.
- Professional independence, which will be addressed in the chapter on the role of the prison health professional and dual obligation dilemmas in this Section.
- Professional competence, which refers to the competences of the prison health professionals and will be addressed throughout the chapters in this Section.²⁷

Monitoring the prison health services aims to get insight into a number of issues, including the ones by the WHO and the CPT as mentioned above, and in addition the following:

- The degree to which prison health authorities take their responsibility in ensuring the right to health for all by having a well-functioning prison health service in place. This should cover amongst other issues the quality of diagnosis, treatment, handling and prevention of communicable diseases, non-communicable diseases, mental health disorders including the risk of suicide and self-harm, substance dependencies and physical disabilities.
- The way in which the prison health service adequately contributes to prisoners' enjoyment of the highest attainable standard of health conducive to living a life in dignity, by providing access to health facilities, goods and services, without discrimination.
- The way in which the prison health service contributes to the prevention, identification and documentation of violence, torture and ill-treatment in the place of detention.

Monitoring methodology

Monitoring the prison health services involves looking into a broad range of issues and obtaining information on these from the various information sources available to the monitor.

When monitoring prison health services, it is important to have knowledge about the availability, accessibility and quality of the health services available in the community, for instance to assess whether equivalence of care for prisoners is achieved and how continuity of care is organized.

27 CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.refworld.org/pdfid/4d7882092.pdf>

Before the monitoring visit, the monitor should consider if there are any aspects of the prison health service which he/she finds particularly important or underexplored in previous visits. This could for instance include the handling of medicine by the prison health staff (and prison guards), the health information system in place, or the continuity of care for prisoners upon entry and after release from the institution. A health monitor should prepare him/herself for the visit by looking into any relevant documentation that can be accessed.

The information sources available to the monitor during the actual monitoring visit include:

- Interviews with prisoners on their experience with the prison health service, including but not limited to the initial medical assessment, waiting times, access to medicines and access to specialized treatment outside the prison.
- Interviews with prison guards on their views and involvement in health care services, including but not limited to their role in communicating with prisoners on access to the prison health services, in giving out medicine to prisoners, and in handling situations of emergency.
- Interviews with prison health staff on the set-up and functioning of the prison health service, including but not limited to the management of resources, reporting lines, clinical independence, dual obligation dilemmas of the prison health professional,²⁸ identification and follow-up on injuries, ill-treatment and torture, involvement in security and discipline, and procedures for managing cases of death in custody.
- Interviews with prison management on their policies and views, including but not limited to the management and organization of, and access to, the prison health service and its integration in/independence of the prison administration.
- Observations. Observations are essential for, inter alia, assessing the overall conditions of the prison health clinic and the storage and availability of medications. Observations can be made both while conducting interviews and during the tour of the clinic and the premises.
- Review of documentation. Looking into documentation includes foremost looking into medical records, written instructions and registers, which should be assessed for their availability, completeness and quality. Medical records will moreover give information about the health care services provided to individual prisoners and the way health issues were followed up on. They may yield important information on the initial medical assessment, access to specialized treatment and care, and equivalence of the treatment and care provided. Regardless of whether a prisoner's informed consent is needed to look into his/her medical file (depending on the mandate of the monitoring team), informed consent is often needed when following-up on the findings in a medical record.

The technical approach by the doctor working in the place of detention may rely on personal competence, availability of diagnostic means and medicine, and his/her willingness to use available resources. Analyzing case records/medical records – particularly those concerning prisoners who during interviews have raised doubts about the appropriateness /quality of the management of their illnesses or traumas - may yield useful information, including:

- As to the prison doctor's competence: An incompetent doctor cannot be expected to offer an appropriate service.
- As to the availability and use of resources: Documentation of availability of necessary resources may be done through an assessment of the prison health clinic and its registers, while documentation of the lack of them or their inappropriate use (and the consequences

28 See for more on dual obligation dilemmas the chapter on the role of the prison health professional and dual obligation dilemmas in this Section.

that follow and impact on the health of prisoners) may be very useful case record information in itself and in the triangulation of information.

- Dual obligations and barriers to providing (optimal) treatment.

The health monitoring matrix is a useful tool for monitoring prison health services. The tool is presented in figure 4 and includes all aspects discussed in the remainder of this Section.

FIGURE 4.
HEALTH MONITORING MATRIX TOOL – PRISON HEALTH SERVICES

Aspects of prison health services	Sources							
	Prisoners	Health staff	Prison guards	Prison management	Observations	Documents		
						Medical records	Registers	Written instructions
Initial medical assessment								
Access to health services								
Continuity of care								
Equivalence of care								
The role of the prison doctor and dual obligation dilemmas								
Medical ethics								
Medical confidentiality								
Informed consent								
The role of the prison health professional in alleged and suspected cases of torture								
Medical records and health information system								
Handling of medicines								
Handling of hunger strikes								
Health promotion and disease prevention								
Palliative care								

During a monitoring visit, crosses could be placed at the information sources used or obtained information could be summarized in the boxes. It is important to choose the right questions for the different groups of interlocutors. Some of the questions should be asked to different groups (and different documents should be investigated), in order to triangulate and get the most complete and reliable assessment of the situation (see for an example box 1 in Section 2).

Further reading

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.ref-world.org/pdfid/4d7882092.pdf>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UN (1982). *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations General Assembly, 1982. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/MedicalEthics.aspx>

CoE (2014). *Prison health care and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being*. Council of Europe (Lehtmet A and Pont J), November 2014. Available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/Publications_HealthCare_manual_Web_A5_E.pdf

3.2. Initial medical assessment

An initial medical assessment refers to the process of assessing the health of a detainee as soon as possible after his/her arrival in a penitentiary institution.

The main purposes of the initial medical assessment are to ensure continuity of care for any illness for which the person is already under treatment, to screen for any health issues requiring urgent attention, to screen for any risk of self-harm or suicide, to identify any signs of torture and/or ill-treatment, to assess the detainee's general health condition and fitness to participate in daily life in the institution, and to inform the detainee about the health services available in the institution and how to access them.

The initial medical assessment can involve several interviews, tests, screenings, assessments and examinations performed by one or more actors, at one or more points in time. Therefore, the process of the initial medical assessment could best be outlined by the following dimensions:

1. Who performs the assessment?
2. What does the assessment involve?
3. When is the assessment performed?

Performing a medical assessment upon entry is key not only for the health of the examined person, but also for the health of others residing in the institution and has as such a preventive function. For example, when a person enters a prison with open tuberculosis, it is essential to detect this as soon as possible in order to start or continue treatment and to prevent the disease from spreading to others in the institution. Other examples include prisoners with a mental illness who could be a danger to themselves or to others when accommodated among other prisoners on a regular ward, or prisoners infected with blood borne diseases such as HIV or Hepatitis B/C who could spread their disease to other prisoners by unsafe injecting or sexual practices.

Usually, prisoners do not refuse to be medically assessed upon entry into an institution. However, it could happen that a prisoner does not want to undergo such an assessment. This situation gives rise to ethical dilemmas as the prisoner should not be forced into the assessment, but at the same time not performing it may put other prisoners and staff, and of course the prisoner him/herself, at risk. It is important that the person performing the assessment clearly explains its purpose, provides information on which tests will be performed (this may include blood tests, a chest X-ray and a urine sample) and explains medical confidentiality. Voluntary cooperation and informed consent of a prisoner to the initial medical assessment should always be sought. Involuntary examinations should only be performed in accordance with law and written instructions as to indications and procedures (see also the chapters on informed consent and medical ethics in this Section). This may for instance be a law allowing for involuntary examinations in case of a suspicion of a serious communicable disease.²⁹

Not much research has been undertaken to investigate the practical implementation and effectiveness of the initial medical assessment. One study that did investigate this, was a study done by Birmingham et al. in the UK in 1997. The results indicated that a considerable amount of morbidity remained undetected during the initial medical assessment due to an ineffective assessment.³⁰

29 See for instance the Danish law on epidemics (Kapitel 4): <https://www.retsinformation.dk/Forms/R0710.aspx?id=210518>

30 Birmingham, Mason & Grubin (1997). Health screening at first reception into prison. *Journal of Forensic Psychiatry*, 8:2, 435-439. Abstract available at: <https://www.tandfonline.com/doi/abs/10.1080/09585189708412022>

A number of factors could hypothetically serve as obstacles for the effective functioning of the initial medical assessment, including:

- Detainees not giving their informed consent to the assessment or to the possible follow-up on its results
- Shortage of medical professionals in the prison health service
- Insufficient guidance regarding the assessment
- Medical professionals being afraid of reprisals for reporting cases of torture and ill-treatment
- Employment of medical professionals within the criminal justice system, leading to a moral identification with the system and unwillingness to report cases of torture and ill-treatment
- Lack of use of interpreters for prisoners not speaking the national language

Relevance to preventive monitoring

The initial medical assessment is of key importance in collecting and assessing allegations and signs of torture and/or ill-treatment that a prisoner may have experienced during the procedures of arrest and transfer as well as in the institution from which he/she may have been transferred. It is a key measure in the fight against impunity and in the prevention of torture and ill-treatment. Ignoring statements, symptoms and signs of ill-treatment or torture may in the worst cases amount to medical complicity in such abuses.

In case safe and effective reporting procedures of alleged cases by the prison health service to the competent investigative authorities are in place, the assessment procedure could ensure that the victim of torture or ill-treatment obtains redress, perpetrators are convicted, and measures to prevent repetition are put in place. In many circumstances, victims of torture or ill-treatment are hesitant to come forward themselves and file a complaint proactively, for instance because of fear of reprisals, lack of trust in the judiciary or due to avoidance symptoms as a part of PTSD symptomatology (i.e. to avoid flash backs re-experiencing the torture).

The initial medical assessment should also identify a prisoner's health-care needs, including any infectious diseases, non-communicable diseases and medications taken. If a serious disease is not identified and/or treated, this may amount to ill-treatment. This is for instance the case if the prisoner is deprived of the necessary treatment he/she is entitled to have, which may lead to suffering and deterioration of his/her health. An example is lack of treatment for abstinence symptoms in prisoners with a drug and/or alcohol dependency. See for more on this issue the chapter on substance use disorders in Section 5.

Furthermore, contracting a severe or even lethal medical condition in prison (e.g. HIV, hepatitis or tuberculosis) may similarly be considered ill-treatment. Performing a thorough medical assessment upon entry is therefore key not only for the health of the examined person, but also for the health of others residing in the place of detention.³¹

Box 3 and 4 include two examples of suboptimal initial medical assessments as found by the National Preventive Mechanism (NPM) in Denmark.

31 Direktoratet for Kriminalforsorgen (2015). *Screening af indsatte for somatiske sygdomme – en undersøgelse af Kriminalforsorgens sundhedsbetjening og de indsatte helbredstilstand*. Direktoratet for Kriminalforsorgen, Copenhagen, 2015. Available at: <https://viden.sl.dk/media/7012/screeningafindsatteforsomatiskesygdomme.pdf>

BOX 3:

CASE EXAMPLE

The NPM in Denmark visited a pre-trial detention facility, where a detainee recently had been hospitalized three to four days after arrival to the facility because of Delirium Tremens – a rapid onset of confusion caused by withdrawal from alcohol.

In the detainee's medical journal in the pre-trial facility, nothing was written about the use of alcohol or withdrawal symptoms or treatment for withdrawal symptoms in the days from arrival to hospitalization. The procedure on arrival in the facility is that prison guards ask newly arrived detainees about the use of alcohol and drugs, but no guidelines existed on when to inform a nurse or medical doctor.

During the monitoring visit and follow up and by triangulating information from interviews with information found in documents from the initial interviews by the prison guards, the monitoring team found out that the detainee had told the prison guard on arrival, that he normally drank 11-12 items of alcohol daily. Furthermore, it became clear that he had asked to see a doctor on arrival.

Whether or not he saw a doctor in the facility before he was hospitalized is unknown. However, no information existed in the detainee's medical journal that he had seen a doctor.

BOX 4:

CASE EXAMPLE

The NPM in Denmark visited a pre-trial detention facility, where alleged police violence from an arrest was not documented.

During the selection of interviews by the monitoring team, a Polish man who did not speak any Danish was selected for an interview as he potentially could be marginalized as well as could lack information on his rights because of the language barrier.

During the interview, the Polish detainee told the monitoring team that he had asked to see a doctor at the initial interview with a prison guard on his arrival to the pre-trial detention facility. The detainee was not offered a translator at this initial interview, and he told the monitoring team that it was impossible for him to communicate with the prison guard. Therefore, he also used a paper application form available in the facility, to apply for a medical examination.

When triangulating this result with information in the client system, it was clear that the detainee was not offered a medical examination at the initial interview with the prison guard.

In the interview with the monitoring team, the detainee furthermore told that he had seen a medical doctor three weeks after his arrival. He was again not offered a translator, and the detainee could not tell the medical doctor about the incident because of the language barrier. When the monitoring team triangulated this information with the detainee's medical journal, it was clear that there was no written information about language problems or alleged police violence at arrest.

The detainee told the monitoring team that he upon arrival to the facility had bruises on his neck as well as a sore neck, and that he wanted to have his bruises documented. By the time he got to see the medical doctor, the bruises were gone.

After its visit, the monitoring team recommended the use of translators at the initial interview with a prison guard and that all detainees at arrival should be offered an assessment by a medical doctor.

The detainee complained about the alleged police violence at the Independent Police Complaints Authority but lost the case.

International standards and guidance

An assessment of the health of newly arrived detainees in criminal justice institutions is internationally considered an important protection of basic human rights. The procedure is described

in several international standards, including the Mandela Rules (Rule 30), the European Prison Rules (Rule 42), the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (principle 24) and the CPT standards (standard 33).

The UN Mandela Rules state in Rule 30 that *'A physician or other qualified health-care professionals, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary'*.

Also other international standards and guidance, such as the CPT standards, the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, and the Guidelines for Prison, Detention and Other Custodial Settings by the Physicians for Human Rights,³² stress the need to conduct an initial medical assessment of prisoners by a member of the prison health services as soon as possible after their entry into the institution. The CPT standards add that the initial assessment could be carried out by a fully qualified nurse who reports to a doctor, which could be considered a more efficient use of available resources.

In the international standards and the literature, the initial medical assessment of detainees as soon as possible after admission is referred to in different ways, including but not limited to: 'initial medical screening', 'initial medical examination', 'initial medical evaluation', 'receiving screening', 'initial reception health screening', 'initial health screening' or 'initial health check'. Regardless of the terminology being used, the procedure may involve several components, which may or may not take place at different points in time after the detainee's arrival in the institution and by different actors.

With regard to the dimensions of the initial medical assessment, as already listed in the introduction, the following can be stated based on the international standards:

1. Who performs the assessment?

The initial medical assessment could be performed by:

- A prison guard
- A social worker
- A nurse or other health professional not being a medical doctor
- A medical doctor
- Any combination of the above

According to the UN Mandela Rules, the initial medical assessment should be carried out by *a doctor or other qualified healthcare professional*. Although this should be considered the gold standard, in practice in many countries around the world, (part of) the assessment is carried out by a non-health professional, often a prison guard or a social worker. For instance, the part on screening for the risk of suicide or self-harm is often undertaken by a social worker with specific expertise in this area ('suicide prevention officer').

A non-health professional carrying out (parts of) the initial medical assessment may be efficient, but at the same time may result in inadequate medical assessments and lack of follow-up on their results. There are also issues with confidentiality of medical data, such as who has access and how is it communicated to health staff (see the chapter on medical records and health information system in this Section). It is of key importance that non-health professionals get

32 PHR (2012). *Dual Loyalty and Human Rights. Guidelines for Prison, Detention and Other Custodial Settings*. Physicians for Human Rights, Boston, USA. Available at: <http://www.webcitation.org/getfile?fileid=cef65358623519e1a0cec3a-010408caf62b99469>

clear instructions from health professionals on how to conduct an initial assessment, on how to ensure medical confidentiality, and on when to refer the person to a more in-depth medical examination by a medical professional.

2. What does the assessment involve?

Rule 30 of the UN Mandela Rules outlines what the initial medical assessment should involve:

A physician or other qualified health-care professionals, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary. Particular attention shall be paid to:

- (a) *Identifying health-care needs and taking all necessary measures for treatment;*
- (b) *Identifying any ill-treatment that arriving prisoners may have been subjected to prior to admission;*
- (c) *Identifying any signs of psychological or other stress brought on by the fact of imprisonment, including, but not limited to, the risk of suicide or self-harm and withdrawal symptoms resulting from the use of drugs, medication or alcohol; and undertaking all appropriate individualized measures or treatment;*
- (d) *In cases where prisoners are suspected of having contagious diseases, providing for the clinical isolation and adequate treatment of those prisoners during the infectious period;*
- (e) *Determining the fitness of prisoners to work, to exercise and to participate in other activities, as appropriate.*

Taking into account the different focus areas as outlined in the Mandela Rules, a proper initial medical assessment could be defined as including most of the following elements:

A quick interview (e.g. by use of a short checklist)

- An in-depth interview
- A physical examination
- A mental health assessment
- Screening for alcohol and/or drug use
- A screening for the risk of suicide or self-harm
- A screening for any signs of torture or ill-treatment experienced prior to admission
- Measurement of blood pressure
- Measurement of body length and weight (BMI)
- Urine test
- Chest X-ray
- Electrocardiogram (ECG)
- Blood test for C-Reactive Protein (CPR)
- Blood test for HIV/AIDS
- Blood test for Hepatitis B/C
- Referral to specialist health services if needed
- A determination of the detainee's fitness and ability to participate in daily life in the institution
- Immediate follow-up on the assessment results – and ensuring treatment, if needed

The assessment should be carried out according to a format that ensures that all necessary information is obtained and that all needs of the person are addressed.

During the initial medical assessment, a detainee may either allege torture or ill-treatment him/herself or the health professional may have the suspicion that he/she may be a victim of torture. For more on this, see the chapter on handling alleged and suspected torture by the prison doctor in this Section.

3. When is the assessment performed?

According to the international standards, the initial medical assessment should be performed as soon as possible after a detainee's arrival in an institution. The European Committee for the Prevention of Torture (CPT) has stated that this should be understood as within 24 hours after admission. This time frame is important with regard to the detainee's health and public health, but also in order to identify possible signs of torture or ill-treatment, signs of stress, and the risk of suicide or self-harm.

Since the assessment can include several elements as outlined above, these often take place at different points in time and are undertaken by different actors.

For instance, an initial 'health check' could be performed by a non-health professional, such as a prison guard or a social worker, according to a standard form/check-list. The detainee is then referred to a health professional for further examination only if this person thinks that this is necessary. In this case, the initial assessment may take place immediately after admission while it will often take a longer time before the detainee gets to see the health professional for a thorough medical examination (if at all). This means that the total process of the initial medical assessment may take place over an extended period of time, usually the first days/weeks after the detainee's arrival in the institution.

Voluntary cooperation and informed consent of a detainee to the initial medical assessment as well as to the follow-up on its results should always be sought.³³

Monitoring methodology

A monitor should assess the practices and procedures in the institution with regard to the initial medical assessment. One of the keys to making useful recommendations for necessary changes is to identify current challenges in the process of conducting the assessment and any shortcomings in its focus areas and follow-up. These shortcomings may for instance include a lack of qualified health care staff available to conduct the assessment, unavailability of diagnostic tools, and poor possibilities for referrals to specialist care.

The monitor should use all information sources available to him/her in order to make a thorough assessment of the practices and procedures and of whether they are in line with international standards and guidance.

The monitor should ask the prison management about the general policies and practices in the institution, and questions that could be asked include for instance whether the institution has instructions for prison (health) staff on how to conduct the initial medical assessment and on how allegations of torture or ill-treatment are being dealt with.

33 UN (2004). *The Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment*. Office of the UN High Commissioner for Human Rights. Available at: <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

PRI & UoE (2017). *Essex paper 3: Initial guidance on the interpretation and implementation of the UN Nelson Mandela Rules, Chapter 4 Health Care*. Penal Reform International and University of Essex, United Kingdom, 2017. Available at: <https://cdn.penalreform.org/wp-content/uploads/2016/10/Essex-3-paper.pdf>

When interviewing prisoners, the monitor could learn about the prisoners' experiences with regard to the initial medical assessment. Questions that could be asked include for instance who conducted the assessment, was it voluntary, what did it include, and did it include any questions on previously experienced torture or ill-treatment.

Interviews with prison health staff will give further insight into the practices and procedures around the initial medical assessment and into its focus areas and follow-up. Questions could for instance include whether the assessment is performed by a health professional and/or a non-health professional, whether it is carried out according to a standard form, what happens in case a prisoner does not consent to the assessment, and how the results are documented and followed-up on.

Prison guards may be able to give insight into the procedure of the initial medical assessment if they are involved in performing it, for instance on which forms are being used and how medical confidentiality is handled/guaranteed. In case the assessment is performed by a health professional, prison guards can inform the monitor about whether and how they are informed about its results, for instance in case a prisoner has a disease or a mental disorder. They could also be asked how the issue of medical confidentiality is being handled.

Observations during the monitoring visit will give insight into issues such as the physical space where the initial medical assessments are carried out and whether this space is in private, out of sight and hearing of others.

The final information source which the health monitor should use during his/her monitoring visit are documents, including any written instructions, registers and medical records that can be accessed. These could include any written instructions and standard forms on how to conduct the initial medical assessment as well as medical records to see how results were documented and followed-up on.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CoE (2006). *European Prison Rules*. Council of Europe, Strasbourg, 2006. Available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.ref-world.org/pdfid/4d7882092.pdf>

Lines R (2008). The right to health of prisoners in international human rights law. *International Journal of Prisoner Health*, March 2008; 4(1): 3-53.

UN (1988). *Body of Principles for the Protection of All Persons under any form of detention or imprisonment*. United Nations General Assembly, A/RES/43/173. Available at: <http://www.un.org/documents/ga/res/43/a43r173.htm>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

3.3 Access to health services

Access to health services means that prisoners have access to health care services, free of charge and without discrimination based on their legal status. Access includes both access to the health services available in the institution as well as access to specialized and emergency services in the community whenever needed. It includes access to the full range of health care services and health professionals, including primary care, emergency care, dental care and specialist care, by doctors, psychologists, dentists and specialists (such as psychiatrists, gynecologists, oncologists etc.).

Access to health care services in places of detention varies broadly between countries and between places of detention within countries. In some countries, health care services in places of detention are still non-existent while in other countries, services are of appropriate quality and easily accessible for all prisoners.

This chapter focusses solely on a prisoner having *physical* access to a broad range of health services, while other chapters in this section deal with issues closely related to this, such as equivalence of care, continuity of care, and medical ethics.

Relevance to preventive monitoring

Lack of access, intentional or unintentional, to health services in a place of detention may amount to ill-treatment. Precluding medical treatment may lead to a decline of a person's health and increase suffering. This may apply to any disease for which there exists treatment possibilities in the general community.

The European Court of Human Rights has received many cases relating to a lack of access to health care services for prisoners and most of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following case is an example of a case judged by the Court as a violation of article 3:

Hummatov v. Azerbaijan 29 November 2007. *The applicant, who had a number of serious diseases, including tuberculosis, alleged in particular that the Azerbaijani authorities had knowingly and willingly contributed to a serious deterioration in his health by denying him adequate medical treatment in prison.*

*The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention, finding that the medical care provided to the applicant in prison in the period after 15 April 2002 had been inadequate and must have caused him considerable mental suffering which had diminished his human dignity and amounted to degrading treatment.*³⁴

In a recent report, the Special Rapporteur on Torture has drawn the attention to the many interrelations between torture and corruption. Access to health care is mentioned in the report as one area that may be affected by corruption, the example being that in inadequately staffed prisons, prison staff may delegate part of internal discipline to dominant inmates who establish systems of corrupt exchanges in which money or favors are exchanged for "privileges", such as having access to medical care.

34 ECHR (2019). *Factsheet – Prisoners' health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

International standards and guidance

Several international standards underline the right of prisoners to have access to health care services.

The UN Basic Principles for the Treatment of Prisoners set out that *'prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'*.³⁵

The UN Committee on Economic, Social and Cultural Rights, which is the independent expert body under the International Covenant on Economic, Social and Cultural Rights (1966), stated in 2000 in its general comment no. 14 that *'The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:*

- *Availability*
- *Accessibility*, which has four overlapping dimensions:
 - Non-discrimination
 - Physical accessibility
 - Economic accessibility (affordability)
 - Information accessibility
- *Acceptability*
- *Quality*³⁶

The Mandela Rules state in Rule 24 that *'the provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community and should have access to necessary healthcare services free of charge without discrimination on the grounds of their legal status'*.

The Mandela Rules elaborate on what the health care services should include. It states that *'every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation. The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner'* (Rule 25). Rule 27 outlines that *'all prisons shall ensure prompt access to medical attention in urgent cases. Prisoners who require specialized treatment or surgery shall be transferred to specialized institutions or to civil hospitals. Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide prisoners referred to them with appropriate treatment and care'*.

The CPT Standards address specifically police custody. The standards outline that every person kept in police custody should have a formally recognized right of access to a doctor. In other words, a doctor should always be called without delay if a person requests a medical examination. Police officers should not seek to filter such requests, meaning that they would have the power to accept or reject them. Further, the right of access to a doctor should include the right of a person in pre-trial detention to be examined by a doctor of his/her own choice (in

35 UN (1991). *Basic Principles for the Treatment of Prisoners*. United Nations resolution, adopted by the General Assembly, 28 March 1991. (Principle 9, A/RES/45/111). Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/BasicPrinciplesTreatmentOfPrisoners.aspx>

36 UN (2000). *Committee on Economic, Social and Cultural Rights General Comment no. 14. The Right to the Highest Attainable Standard of Health* (art. 12). August 2000. Available at: <http://www.refworld.org/pdfid/4538838d0.pdf>

addition to any medical examination carried out by a doctor called by the police authorities, e.g. for the medical examination upon entry). This is also stated in the Mandela Rules, Rule 118: *'An untried prisoner shall be allowed to be visited and treated by his or her own doctor or dentist if there are reasonable grounds for the application and he or she is able to pay any expenses incurred'*.

Upon arrival to a place of detention, a person must be informed about the procedure how to request and access health care services. This includes access to a general practitioner as well as access to mental health care services, dental health services, reproductive health care services and specialized care. In practice, different places of detention have different procedures for prisoners requesting access to the health care services available in the institution. Some prisons have postal boxes through which prisoners can pass requests, while others rely on prison staff to communicate the prisoner's request to healthcare staff. Prisoners' requests to access healthcare services should never be filtered by prison staff. In case that prison staff is responsible for communicating requests of prisoners to prison health staff, there is always the danger that confidential information may be passed on to other staff or prisoners, which needs to be carefully monitored for.

Prisoners who need to have access to specialized health care services which are not available in the institution should be able to access these services in the outside community. Access should be granted by the prison health staff. However, granting access is not limited to the power and availability of prison health staff and also the prison management and prison guards have an important role in ensuring this access, as security and administrative procedures may sometimes be complicated.

Language barriers may lead to decreased access to health services for prisoners who do not speak the national language and therefore cannot express their needs. Use of interpreters is important to ensure that foreign national prisoners and other prisoners not speaking the national language have access to health care services on an equal basis as others.

Monitoring methodology

A monitor should assess the practices and procedures in the institution with regard to prisoners' access to a broad range of health services, both in the institution and, whenever needed, in the general community.

The monitor should ask the prison management about the general procedures and practices in place. Questions that could be asked include for instance what the general procedure is for prisoners to request access to health care services and what the role of prison staff is in granting this access.

Interviews with prisoners could give the monitor further information about how access is obtained in practice and whether they were informed about the procedures when they entered the institution. Prisoners may be able to give examples of situations where access was denied or suboptimal.

Interviews with prison health staff will give the monitor further information about the access to health services. Questions that could be asked include for instance how long the average waiting time is for a prisoner who requests to see a doctor, how access to specialized health care services is guaranteed, and whether they experience challenges when wanting to refer prisoners for treatment outside of prison (for instance, dilemmas due to security reasons).

Prison guards may be able to give further information about the procedure of getting access to the health services in the institution. The monitor could ask them what their role is in a prisoner

obtaining access to the health care services and whether and how confidentiality of medical issues is ensured in the process of prisoners getting access.

Observations should focus on the physical accessibility of the prison health clinic, in particular for prisoners who have a physical disability.

Documents should be consulted, for instance whether there are written instructions in place for prisoners on how to access the health services in the institution, and for prison health professionals on how to refer to specialized health care services if needed.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.ref-world.org/pdfid/4d7882092.pdf>

UN (1966). *International Covenant on Economic, Social and Cultural Rights*. United Nations Office of the High Commissioner for Human Rights. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

3.4 Continuity of care

Continuity of care (or 'throughcare') refers to the continuation of health care, including medication and necessary medical check-ups, for persons with health conditions – physical as well as mental - entering the criminal justice system, being transferred between different institutions within the criminal justice system, on temporary leave from an institution, and upon release into the community.

Continuity of care is of utmost importance for prisoners. This applies especially to prisoners with e.g. a chronic and/or infectious disease in need of daily medication and medical follow-up, for instance prisoners with infectious diseases, mental health diseases, diabetes, hypertension and heart diseases, and to prisoners on opioid substitution treatment.

However, lack of coordination between the health services of different places of detention as well as between those institutions and the community health services often causes problems, i.e. foremost the discontinuation of treatment and/or medications. Barriers to continuity of care have been documented in several countries³⁷, and include for instance:

- Limited contact and interaction between prison health services and community health services (often due to prison health not being part of public health and the responsibility of another Ministry than the Ministry of Health)
- Weak (or absent) prison health (and/or general health) system
- Referrals not being received in the community, due to different recording systems
- Lack of contact details of ex-prisoners after release, making follow-up difficult
- Lack of procedures for hand-over of health information in connection with transfers between institutions

Relevance to preventive monitoring

Failure to ensure continuation of necessary treatment may have serious consequences for the person and may amount to ill-treatment. Discontinuation of treatment and care may very well lead to progression of the disease in question (e.g. heart failure, asthma, diabetes, TB, HIV), causing unnecessary suffering and in worst case implying a threat to the life of the person. Moreover, in case of an infectious disease, it may increase the risk of development of resistance to antibiotics and it may expose fellow prisoners, staff members and visitors to a risk of transmission. When a prisoner leaves a place of detention with an insufficiently treated infectious disease, such as TB or HIV, this poses a threat to overall public health.

The European Court of Human Rights has received many cases relating to a lack of continuity of care for prisoners and some of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following case is an example of a case judged by the Court as a violation of article 3:

37 Abbott et al (2017). Supporting continuity of care between prison and the community for women in prison: a medical record review. *Aust Health Rev.* 2017 Jul;41(3):268-276. Doi: <https://doi.org/10.1071/AH16007>
Gulland (2010). Continuity of health care for prisoners on release in England is worsening. *BMJ* 2010;340:c2949. Doi: <https://doi.org/10.1136/bmj.c2949>
Kouyoumdjian et al (2015). Optimizing continuity of care throughout incarceration. Case and opportunities. *Can Fam Physician.* 2015 Feb; 61(2): 107–109. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4325853/> *Hatwiinda et al (2018). Poor continuity of care for TB diagnosis and treatment in Zambian Prisons: a situation analysis. *Trop Med Int Health.* 2018 Feb;23(2):243-250. Doi: <https://doi.org/10.1111/tmi.13024>

Kolesnikovich v. Russia 22 March 2016. The applicant, who had problems with an ulcer as well as brain and spinal injuries, alleged that his health had deteriorated in detention, in particular because of the failure to provide him with the medication he had been prescribed with for treating his illnesses. He also maintained that the prison doctors had merely provided symptomatic treatment to him and had failed to adopt a long-term therapeutic strategy. He lastly submitted that he had not had an effective avenue through which to complain about the inadequacy of his medical care in detention.

The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention. It noted in particular that, even though the authorities had become promptly aware of the applicant's health problems, he had been left without any medical supervision during the first two years of his detention, until his health had worsened to the extent that he could no longer take part in court hearings. His delayed admission to the prison hospital, combined with the failure to provide him with some of the required medication in order to, at least, relieve his severe stomach pain, had also been a serious shortcoming. The Court was further not convinced that the authorities had properly assessed the complications of the applicant's condition. His treatment had lacked a strategy aimed at reducing the frequency of ulcer recurrence and had therefore been patently ineffective. A major flaw in that respect was the failure to perform the *Helicobacter pylori* test. Moreover, the authorities did not seem to have assessed the compatibility of the applicant's treatment with nonsteroidal anti-inflammatory drugs for his spinal problems with his ulcer disease, even though such medication could induce gastrointestinal bleeding and deterioration of the patient's condition. The Court found that all those shortcomings, taken cumulatively, had amounted to inhuman and degrading treatment.³⁸

International standards and guidance

Mandela Rule 24 states that 'health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence'.

The United Nations Office on Drugs and Crime (UNODC) states in its Policy brief on HIV prevention, treatment and care in prisons and other closed settings that 'in order to ensure that the benefits of treatment (such as antiretroviral therapy, tuberculosis treatment, viral hepatitis treatment or opioid substitution therapy) started before or during imprisonment are not lost, as well as to prevent the development of resistance to medications, provision must be made to allow people to continue these treatments without interruption, at all stages of detention: while the person is in police and pretrial detention, in prison, during institutional transfers and after release'.³⁹

On a national level, some countries have issued guidelines specifically addressing continuity of care. For example, the National Institute for Health and Care Excellence in the United Kingdom has in November 2016 published guidelines and recommendations on physical health of people in prison, which includes a section on continuity of healthcare.⁴⁰

Ensuring continuity of care should be a joint responsibility of prison health services and community health services and a close collaboration between the two must exist. It should be regarded as part of an (ex-) prisoner's reintegration into the society. It is ultimately the responsibility of the Ministry of Justice/Interior or Ministry of Health (in some countries both, necessitating

38 ECHR (2019). *Factsheet – Prisoners' health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

39 UNODC (2013). *Policy Brief on HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*. United Nations Office on Drugs and Crime, 2013. Available at: https://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

40 NICE (2017). *Physical health of people in prisons*. National Institute for Health and Care Excellence, 2017. Available at: <https://www.nice.org.uk/guidance/qs156/resources/physical-health-of-people-in-prisons-pdf-75545543334085>

a cooperation between the two) to ensure that a prisoner receives the treatment to which he/she has the right - regardless any transfer.

Electronic medical records that can be accessed by health professionals inside the criminal justice system as well as by those in the community, would facilitate continuity of treatment and care by way of easy information sharing. However, in many countries this is not the case and medical records in places of detention are often not electronic but in written form. Also, in some contexts, information regarding a person's status as a prisoner might be revealed through such joint medical records which may hinder their use.

When a prisoner is on medication, he or she should upon release from the institution be provided with a stock of medication sufficient to ensure continuity of treatment until community health care takes over. Prisoners should be provided with a complete copy of their medical files, including the results of all tests conducted during imprisonment, ensuring that the relevant information (via the ex-prisoner) reaches the doctor in the community. When a prisoner is transferred between different places of detention and electronic files do not exist, the health professionals must ensure that a hard-copy of the medical file follows the prisoner.

Monitoring methodology

A monitor should look into the procedures and practices of the institution with regard to ensuring prisoners' continuity of care when entering the criminal justice system, being transferred between different institutions within the criminal justice system, on temporary leave from the institution, and upon release to the community.

The prison management could for instance be asked about any instructions the institution may have gotten from the Ministry of Health or the Ministry responsible for prison health in relation to continuity of care.

Interviews with prisoners will be very useful in gaining insight into prisoners' experience with continuity of care. Questions that could be asked include for instance whether the prisoner could continue any treatment/medications he/she received before his/her imprisonment and whether his/her medical file has followed him/her in case he/she has been transferred between institutions.

Prison health staff will be able to inform the monitor about the daily practice and any instructions/guidelines that may be in place to guarantee continuity of care. The monitor could ask the prison health professionals about their interaction and cooperation with health services in the community and about whether a prisoner who is on daily medication gets a stock of medication with him/her when he/she is (temporarily) released.

Prison guards will not be able to provide much information on this specific topic, apart from possibly having seen examples of poor continuity of care. This could for instance involve a prisoner who got sicker the longer he/she was imprisoned, due to disruption in his/her medication or treatment.

Finally, the monitor should consult any relevant documentation available to him/her, which could give more insight into how the institution ensures continuity of care. These could for instance include medical records of prisoners, the register on dispensing of medicines (if available), and forms and guidelines related to the initial medical assessment (to assess its completeness so that continuity of care can be guaranteed).

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

3.5. Equivalence of care

*'Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.'*⁴¹

Equivalence of care refers to the provision of health care in places of detention of similar standards as available in the community, ensuring that prisoners have access to necessary health-care services free of charge and without discrimination on the grounds of their legal status.

Equivalence of health care in places of detention can refer to a broad range of issues, namely equivalence with regard to the following aspects:

- The availability of health care in general as well as specialized health care
- The accessibility to all types of health care (see also the chapter on access to health care)
- The acceptability of the health care
- The quality of the health care, including information about treatment options

In this chapter equivalence of care refers to equivalence of all these aspects, i.e. availability of, access to, acceptance of, and quality of health care services leading to equivalent outcomes as would have been obtained by the health care services in the community.

Many prisoners come from poor and marginalized groups in the society and often have had limited health care prior to their imprisonment and limited awareness of existing possibilities for health services and their rights to use such services. The place of detention gives a unique opportunity to reach this normally hard-to-reach groups within society and to improve their health status, which will ultimately facilitate their reintegration into the community after having served their sentence and benefit overall public health. For example, a prisoner entering the institution with a drug dependency who is able to start opioid substitution therapy in the institution, is more likely to be stabilized and capable of integrating into the community upon his/her release than before the imprisonment (of course if continuity of care is guaranteed). Another example could be a prisoner entering the institution with Tuberculosis. If proper treatment and care is available, he/she will be able to recover from the disease and reintegrate into the community without spreading the disease to others, i.e. benefitting overall public health.

Relevance to preventive monitoring

Not providing prisoners with a level of health care that is equivalent to that provided in the local community may have serious consequences for the individual and may in some cases be regarded as ill-treatment. Not providing treatment and care as available in the local community may very well lead to progression of a disease (e.g. heart failure, asthma, diabetes, TB, HIV, withdrawal symptoms), causing unnecessary suffering and in worst case implying a threat to the life of the person.

The European Court of Human Rights has received many cases relating to a lack of equivalence of care for prisoners and most of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following case is an example of a case judged by the Court as a violation of article 3:

41 UN (1982). *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations General Assembly, 1982. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/MedicalEthics.aspx>

Holomiov v. the Republic of Moldova 7 November 2006. The applicant alleged that he was detained in inhuman and degrading conditions and that he had not been provided with proper medical care. According to medical certificates submitted by him he suffered from a number of serious illnesses including chronic hepatitis, second-degree hydronephrosis, chronic bilateral pyelonephritis with functional impairment of the right kidney, hydronephrosis of the right kidney with functional impairment, and chronic renal failure.

The Court noted in particular that the parties disagreed about the availability of medical care in prison. It considered, however, that the core issue was not the lack of medical care in general but rather the lack of adequate medical care for the applicant's particular conditions. In the present case, the Court observed that, while suffering from serious kidney diseases entailing serious risks for his health, the applicant had been detained for almost four years without appropriate medical care. It therefore found that the applicant's suffering has constituted inhuman and degrading treatment.⁴²

Box 5 includes an example of inequivalence of care found by the NPM in Denmark.

BOX 5:

CASE EXAMPLE DENMARK, NPM VISIT TO A PRE-TRIAL DETENTION FACILITY

During an NPM visit the team interviewed a detainee who suffered from a bleeding disorder (Hemophilia). The detainee experienced that the physical environment in the pre-trial detention facility deteriorated his medical condition as he did not have access to the assistive devices that his specialist medical doctor had recommended.

His specialist medical doctor and the medical doctor in the pre-trial detention facility had both recommended that a multi-disciplinary approach, including access to training devices (soft dumbbells, elastic for training) as well as a special chair, mattress and pillow, was essential - something he would have access to in the outside community. At the time of the visit, the management had not followed any of the recommendations given by the medical doctors. They argued, that soft dumbbells would be compromising the security in the facility.

After the visit, where the NPM team pointed this out to the management, the management offered the detainee to move to another pre-trial detention facility where the physical environment would allow for the recommended assistive devices.

International standards and guidance

The principle of equivalence of care is outlined in several international standards, all outlining that prisoners shall have access to health care of the same standards as available in the community.

The Basic Principles for the Treatment of Prisoners outline in point 9: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation".

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) state in their standards (38) that 'A prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community'.

In line with the above, Rule 24.1 of the Mandela Rules outlines:

'The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to

⁴² ECHR (2019). Factsheet – Prisoners' health-related rights. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

necessary health-care services free of charge without discrimination on the grounds of their legal status'

In spite of the clear messages regarding the need for equivalence of care, its implementation is challenging. For instance, current policy in the UK and elsewhere seems to focus on the measurement and achievement of equivalence in the *process* of provision of health care, which is not sufficient as it does not necessarily address the key challenges. These challenges include foremost:

- The composition of the prison population (higher prevalence of many diseases than in the general community, e.g. TB, HIV, substance abuse and mental disorders)
- The prison setting (e.g. the manner in which diseases are transmitted in combination with prison health factors jeopardizing the prisoners' health)⁴³

Prisoners suffer a disproportionate burden of health problems as their health needs are often neglected and health services available to them are limited and/or of poor quality. One may therefore argue that achieving equivalence of care is not enough and prisoners are in fact in need of more health care than people living in the general community⁴⁴, for the following reasons:

1. Many prisoners have an elevated need for health care. The health needs of prisoners are often more intensive and complex than the health needs of an average person outside prison, demanding a more intensive and complex response by the health care service. Health care services in prisons must therefore have a different orientation from that offered to the general population.⁴⁵
2. Prisoners are entitled to get treatment for their diseases which they did not get in the general community before their imprisonment, and the prison health care service must now fill the gaps.
3. Prison health factors which may be detrimental to health (for instance passive smoking and poor nutrition) will further add to the demands of the prison health care services.

Equivalence of care can be used as an argument in the discussion with authorities if/when deficiencies are addressed. In this process, the issue of barriers for prisoners' access to health care, for provision of health care and for achieving a quality that is equivalent to what exists in the community should be addressed. The barriers may for instance consist of logistical challenges, regulations for security in conflict with a smoothly working health system, and scarcity of staff members, equipment, medicine and other treatment modalities.

A key challenge is referring to equivalence of care in cases where the health care available in the community is of very poor standards. In such case reference to equivalence is not that useful and it might be better to refer to prisoners' right to health care from a human rights perspective.

Monitoring methodology

Assessing equivalence in health care is often a very complicated task for a monitor. It requires a detailed knowledge of the health care system outside the prison and a detailed assessment

43 Charles and Draper (2011). 'Equivalence of care' in prison medicine: is equivalence of process the right measure of equity? *J Med Ethics* 2012;38:215-218. <http://dx.doi.org/10.1136/medethics-2011-100083>

44 Lines (2006). From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons. *International Journal of Prisoner Health*, December 2006; 2(4): 269-280. Available at: http://www.iprt.ie/files/equivalence_paper_final_ijph.pdf

45 Niveau (2007). Relevance and limits of the principle of "equivalence of care" in prison medicine. *J Med Ethics*. 2007 Oct; 33(10): 610-613. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652802/>

of the system inside the prison. Very few prisoners would have the background to assess equivalence of care adequately and prison (health) staff could be biased in their opinions. Therefore, when monitoring equivalence of care, a monitor should focus – through interviews with all relevant persons as well as observations and reviews of documents - on all aspects of equivalence, i.e. availability, accessibility (incl. waiting lists), acceptability and quality of the prison health care available.

The monitor should ask the prison management about the general situation and about how the institution aims to achieve equivalence of health care as available in the community. The management could for instance be asked about their view on the availability of, access to, and quality of the health care services in the institution.

Interviews with prisoners should focus on their perceptions with regard to availability of, access to and quality of health care services in the institution and on how this compares to the care they may have received in the outside community.

Prison health staff are a very useful information source when monitoring equivalence of care as they will probably be in the best position to assess this. Some will have experience working in the general community before they started working for the prison health service or currently work there as well. Questions that could be asked include for instance which type of health care services are available to the prisoners and whether there are barriers and challenges related to the provision of care equivalent as in the community, asking them to elaborate on these.

Prison guards will be able to give the monitor more information on the availability of health care services in the institution and the access to these services. Questions that could be asked include for instance how prisoners get access to the health care services and if they see any challenges or barriers in this process.

Reviewing documents will be useful, for instance to check which health care services are offered in the institution and to see what the average waiting times are for prisoners accessing the health services.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.ref-world.org/pdfid/4d7882092.pdf>

UN (1991). *Basic Principles for the Treatment of Prisoners*. United Nations resolution, adopted by the General Assembly, 28 March 1991. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/BasicPrinciplesTreatmentOfPrisoners.aspx>

UN (2015). UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

3.6. The role of the prison health professional and dual obligation dilemmas

In the majority of prison systems worldwide, a health professional is connected to a place of detention. He/she is either available within the institution on a regular basis, as part of a prison health clinic, or reachable on call in case needed. The prison health professional has a key role in the provision of medical care and treatment to prisoners similar to what a health professional working in the community has towards his/her patients, but in addition he/she has a few more obligations.

As described by Pont et al., according to the international standards and guidelines a prison health professional's task consists of the following elements:

- Acting as a private caregiver to prisoners
- Advising the prison director on health affairs in the prison
- Acting as a health and hygiene officer by inspecting and reporting on food, hygiene, sanitation, heating, lighting, ventilation, clothing, bedding and physical exercise⁴⁶

In addition to the tasks listed above, an important task of the prison health professional is to attend to prisoners that are kept in isolation and/or restrained.

The above means that the role of the prison health professional is much broader than merely providing individual treatment and care to prisoners.

Health professionals working in places of detention may have conflicting obligations and responsibilities, due to the circumstances of their employment. Dual obligation dilemmas in places of detention can be defined as the conflict between professional duties to a patient and obligations, express or implied, to the interests of the employer, i.e. the prison administration/state authority.

Relevance to preventive monitoring

No matter the conditions of employment of a health professional working in a place of detention, his/her fundamental duty is always to act in the best interest of his/her patient, i.e. the prisoner (see also the next chapter in this Section on medical ethics). Issues of dual obligations may have serious consequences for a prisoner. For instance, a health professional may be required to certify a prisoner's fitness for isolation, which should not be the case. Isolation is likely to be detrimental for the prisoner's health and well-being. Under certain conditions, isolation could amount to ill-treatment or torture, for instance if a person with a mental disorder is placed in isolation for an extended period of time, which may worsen his/her condition (see also the chapter on the use of solitary confinement in Section 4). Another example concerns dealing with a prisoner on hunger strike, where the health professional may be required by the prison administration to force-feed the prisoner against his/her own will to prevent a death in custody. Such practices are violating international medical ethical standards and should never be pursued (see also the chapter on handling of hunger strikes in this Section).

International standards and guidance

Several international rules, resolutions, declarations and recommendations by e.g. the United Nations, the World Medical Association, and the International Council for Nurses⁴⁷ state that

46 Pont et al. (2012). Dual loyalty in Prison Health Care. *American Journal of Public Health*, March 2012, Vol 102, No. 3. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3487660/>

47 See the website of the International Council of Nurses: <https://www.icn.ch/>

the sole task of health care professionals working in prisons is the care of physical and mental health of the prisoners.

The Mandela Rules include several Rules which relate to the issue of dual obligations. Mandela Rule 27 states in relation to clinical independence that *'clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical staff'*.

Mandela Rules 30-34 recognize that the role of healthcare professionals in prison must be clearly separate from that of the prison administration. The same ethical and professional standards apply to healthcare staff working in places of detention as to those working in the outside community. Health professionals' role in a place of detention is to evaluate, promote and treat the physical and mental health of their patients and health professionals must not be involved in prison management issues, such as disciplinary measures. Moreover, prison health professionals have a duty to document and report any signs of torture or other cruel, degrading or inhumane treatment (with informed consent of the patient). Proper procedural safeguards (e.g. confidentiality and informed consent) shall be followed in order not to expose the prisoner or others to reprisals. Also, the doctor must report to the director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

The CPT standards underline the need for independence of health professionals working in prisons in standard 72: *'Whatever the formal position under which a prison doctor carries on his activity, his clinical decisions should be governed only by medical criteria. The quality and the effectiveness of medical work should be assessed by a qualified medical authority. Likewise, the available resources should be managed by such an authority, not by bodies responsible for security or administration'*.

In most countries, the Ministry of Justice or Interior, which is responsible for the management of places of detention, is also responsible for the provision of health care in those places. This means that health professionals working in places of detention are often employed by the Ministry of Justice/Interior, unlike medical professionals working in the community, who are usually employed by the Ministry of Health. They report to prison management and in this way are at risk of losing (part of) their professional independence.

Prison administrations and health authorities, although ultimately serving the same government, have often completely different and conflicting interests. The prison administration's task is safety and security, law enforcement and if needed, discipline. The health authority's task is health care to improve persons' health and well-being. These conflicting interests impact on the work of a medical professional in a place of detention.

When prison health professionals are employed by the prison administration, they are especially vulnerable to pressures to serve medical purposes other than patient care. This for instance arises when a doctor, whose role should be caregiving and prioritizing the health and well-being of his/her patient, gets a role in medical examinations and treatment related to another purpose, such as forensic reports. Then the doctor needs to reveal medical information about the patient, which otherwise would be confidential. Another example is when a doctor is asked to force-feed a prisoner on hunger strike against his/her own will. This is never acceptable and clearly indicates the pressure which a doctor may experience to act in the interest of the prison administration instead of adhering to his/her principles of medical ethics.

It is important that the health professional working in a place of detention has mechanisms in place to be able to resist possible pressure by the prison administration to act in a suboptimal way for the patient. This includes that they are in regular contact with their medical association,

if appropriate in the respective country, and that they can report to a professional body in case of concerns about the health of a prisoner when his/her recommendations are not followed.⁴⁸

Health professionals also face an ethical conflict in a prison where their duty is to protect the health of prisoners when e.g. the material and/or psychological living conditions of those prisoners - whether through lack of resources or deliberate neglect by the prison authorities - constitute a risk to the health of prisoners. In such cases, health professionals can uphold the best interests of their patients by reporting on sanitary and living conditions, both to the prison authorities and the involved Ministries. They have a duty to speak out when the services, treatments and conditions in the institution are unethical, abusive, inadequate and harmful for prisoners' health. The prison doctor could always seek advice from his/her medical association in these circumstances, if appropriate in the respective country.⁴⁹

Over the last years, international organizations including the World Health Organization, have stated that the task of a prison health professional can be best fulfilled if he/she has true independence from prison authorities and that - although prison health professionals' physical placement in a place of detention makes this challenging - no matter what, this will be facilitated best when prison health services are under the responsibility of a country's Ministry of Health.⁵⁰

In this situation, prison health staff report to the Ministry of Health and will direct their advocacy efforts (for instance for increased funding) through the Ministry of Health as well. In this model, the 'patient' towards whom the prison health staff has a duty of care, can be seen as more separate from the 'prisoner', i.e. the person under treatment is more likely to be seen as a patient than as a prisoner.

During the last decennia, a number of countries and regions around the world have transferred the responsibility for prison health services from their Ministry of Justice/Interior to the Ministry of Health (including, but not limited to England and Wales, Norway, France, Geneva (Switzerland), Italy (most regions), Spain (2 autonomous regions), New South Wales (Australia), UN Administered Province of Kosovo). With this model, inclusion of prisons in national health strategies is likely to be better secured and equivalence and continuity of care are more likely to be achieved, for instance by inclusion of medical records in a national system of electronic medical records and by well-functioning referral systems.

Possibilities for referral of prisoners in need of treatment in the outside community may be easier. In its publication 'Good governance for prison health in the 21st century; A policy brief on the organization of prison health', WHO Regional Office for Europe stresses that '*health ministries should provide and be accountable for health care services in prisons and advocate for healthy prison conditions*' and that governance of prison health by a country's Ministry of Health is likely to lead to:

- Improved quality of health care in prison
- Inclusion of prisons in public health initiatives
- Uninterrupted continuity of care when prisoners are admitted, transferred or released
- Completion of epidemiological surveillance

48 FFLM (2019). *Quality Standards for healthcare professionals working with victims of torture in detention*. Faculty of Forensic & Legal Medicine, 2019. Summary of the full report available at: https://fflm.ac.uk/wp-content/uploads/2019/05/HWVT_summary_May-2-2019-published.pdf

49 Some medical associations are more involved in this topic than others. For instance, the Norwegian Medical Association has developed an online course on human rights and ethical dilemmas for doctors working in prison (NMA, 2004).

50 WHO Europe/ UNODC (2013). *Good governance for prison health in the 21st century. A policy brief on the organization of prison health*. World Health Organization Regional Office Europe & United Office on Drugs and Crime, Copenhagen, 2013. Available at: http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf?ua=1

- Better recruitment and qualification and less isolation of prison health professionals⁵¹

What is most important is that prison health services are equivalent to those in the wider community (in terms of availability, accessibility, quality and effectiveness), have close connections with public health services and that prison health professionals have their professional independence, regardless of which Ministry they work for. In the end, the management and coordination of prison health services by all relevant and involved agencies and the availability of the resources necessary for the health and well-being of persons kept in places of detention is a whole-of-government responsibility.

BOX 6:

GUIDELINES BY PHYSICIANS FOR HUMAN RIGHTS

Physicians for Human Rights issued a report on Dual Loyalty & Human Rights which includes Guidelines for Prison, Detention and Other Custodial Settings. These guidelines can be used as a useful reference when monitoring dual obligations of prison health professionals, specifically the following:⁵²

- The health professional should act in the best interests of his or her patient at all times.
- The health professional is responsible for ensuring physical and mental health care (preventive and promotive) and treatment, including specialized care when necessary; ensuring follow-up care; and facilitating continuity of care— both inside and outside of the actual custodial setting— of convicted prisoners, prisoners awaiting trial, and detainees who are held without charge/trial.
- The health professional must be ensured, and must insist on, unhindered access to all those in custody.
- The health professional must regularly inspect and report on sanitary, living and general health conditions to the custodial authority and an independent medical authority; and should, when necessary, advocate for better custodial conditions with custodial authorities and/or an independent medical authority.
- The health professional should report to the custodial authorities and, where appropriate, to an independent medical authority any situation in which he or she becomes aware of allegations or evidence that those in custody are being subjected to torture or cruel, inhuman or degrading treatment. The health professional must, however, weigh this action against any reprisal or further punishment to the prisoner that may result. When appropriate, the health professional should gain the consent of the prisoner before making such a report.
- The health professional should certify only that which he or she has personally verified; should not falsify evidence and should ensure that complete and accurate medical records are kept for all patients.
- The health professional should abstain from participating, actively or passively, in any form of torture.
- The health professional should not provide any means or knowledge to facilitate the practice of torture or cruel, inhuman, or degrading treatment or punishment; should not authorize, approve, or participate in punishment of any form, in any way, including being present when such procedures are being used or threatened.
- The health professional should not participate in capital punishment in any way, or during any step of the process. This includes an examination immediately prior to execution and one conducted after the execution has been carried out.
- The health professional should respect medical confidentiality; should insist on being able to perform medical duties in the privacy of the consultation, with no custodial staff within earshot; should divulge information strictly on a need-to-know basis, when it is imperative to protect the health of others.
- The health professional should have the unquestionable right to make independent clinical and ethical judgements without untoward outside interference.

(Continues)

51 WHO Europe/ UNODC (2013). *Good governance for prison health in the 21st century. A policy brief on the organization of prison health*. World Health Organization Regional Office Europe & United Office on Drugs and Crime, Copenhagen, 2013. Available at: http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf?ua=1

52 Quoted from <http://www.webcitation.org/getfile?fileid=cef65358623519e1a0cec3a010408caf62b99469>

- The health professional should not perform any medical duties on shackled or blindfolded patients, inside or outside the custodial setting. The only exception should be in circumstances where, in the health professional's judgment, some form of restraint is necessary for the safety of the individual, the health professional and/or others, and treatment cannot be delayed until a time when the individual no longer poses a danger. In such circumstances, the health professional may allow the minimum restraint necessary to ensure safety.
- The health professional should not perform medical duties or engage in medical interventions for security purposes.
- The health professional should not participate in police acts like body searches or the imposition of physical restraints unless there is a specific medical indication for doing so or, in the case of body searches, unless the individual in custody specifically requests that the health professional participate. In such cases, the health professional will ascertain that informed consent has been freely given, and will ensure that the prisoner understands that the health professional's role becomes one of medical examiner rather than that of clinical health professional.⁵³

Monitoring methodology

When monitoring the role of the prison doctor and dual obligation dilemmas in the institution, the monitor should consult as many sources of information as possible to assess whether practices and procedures are in line with international standards and guidance. During the monitoring visit, these information sources include interviews with prisoners, prison health staff, prison guards, and prison management, observations and looking into available documentation. The Guidelines for Prison, Detention and Other Custodial Settings by the Physicians for Human Rights, as were outlined in box 6, can be used as a useful reference.

The monitor should ask the management about the general policies and practices in the institution, with regard to the organization and management of prison health care and management's interaction with the prison health professionals. They could for instance be asked whether there are any cases where they have interfered with the decision of the prison doctor. They could also be asked whether they are regularly advised by the prison health professionals on health affairs in the institution, such as food, hygiene, sanitation, heating, lighting, ventilation, clothing, bedding and physical exercise.

Interviews with prisoners could give the monitor information about their perception of the doctor's independence from the prison administration. The prisoners could for instance be asked if they could give some examples of interference of management in the implementation of the doctor's decisions or recommendations, if they are aware of such, and/or have personal experience.

When interviewing prison health staff, the monitor could ask about the different tasks of the prison health professionals in the institution. They could also be asked directly into dual obligation dilemmas, e.g. to whom they report in their daily work and whether they face any challenges with regard to dual obligations (asking them for examples, for instance declaring a prisoner fit for isolation).

Prison guards may be asked whether they are aware of cases where management interfered with decisions by a prison health professional, or where a health professional was involved in issues like isolation of a prisoner, restraining a prisoner, force feeding during a hunger strike, etc.

Observations are mostly relevant in case the interaction between the prison management and the prison health professionals can be observed, to assess their communication and dynamics.

53 PHR (2012). *Dual Loyalty and Human Rights. Guidelines for Prison, Detention and Other Custodial Settings*. Physicians for Human Rights, Boston, USA. Available at: <http://www.webcitation.org/getfile?fileid=cef65358623519e1a0cec3a-010408caf62b99469>

The monitor should look into any accessible documents which may give additional information. This includes for instance looking into medical records to identify cases where management has interfered with a decision by the prison doctor. The monitor should also look for documents where the prison health service has inspected the institution on health aspects, including food, hygiene, sanitation, heating, lighting, ventilation, clothing, bedding and physical exercise as well as the prison management reaction to this.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.ref-world.org/pdfid/4d7882092.pdf>

NMA (2004). *Doctors working in prison: human rights and ethical dilemmas*. Online Course. Norwegian Medical Association, 2004. Available at: <https://nettkurs.legeforeningen.no/course/view.php?id=39>

PHR (2011). *Dual Loyalties: The Challenges of Providing Professional Health Care to Immigration Detainees*. Physicians for Human Rights, Boston, USA. Available at: https://s3.amazonaws.com/PHR_Reports/2011_DualLoyalties_Final_3_24_2011_opt.pdf

PHR (2012). *Dual Loyalty and Human Rights. Guidelines for Prison, Detention and Other Custodial Settings*. Physicians for Human Rights, Boston, USA. Available at: <http://www.webcitation.org/getfile?fileid=cef65358623519e1a0cec3a010408caf62b99469>

Pont J et al. (2012). Dual loyalty in Prison Health Care. *American Journal of Public Health*. March 2012, Vol 102, No. 3. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3487660/>

CoE (2019). *Organisation and management of health care in prison*. Council of Europe (Jörg Pont & Timothy Wilfrid Harding), 2019. Available at: <https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

WHO Europe/UNODC (2013). *Good governance for prison health in the 21st century. A policy brief on the organization of prison health*. World Health Organization Regional Office Europe & United Nations Office on Drugs and Crime, Copenhagen, 2013. Available at: http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf?ua=1

3.7. Medical ethics

Medical ethics can be defined as the system of moral principles that apply values to the practice of clinical medicine. In relation to places of detention, it relates to the code of conduct considered to be morally correct for prison health professionals.

According to the international standards, the sole task of a health care professional in places of detention is the care of the physical and mental health and well-being of the prisoners.⁵⁴ All tasks must be performed with complete loyalty to the prisoners solely. Activities which prison health professionals should stay away from include, for instance, disclosure of patient medical data to others without consent of the patient, assisting in body searches and other security- or disciplinary measures, force-feeding and torture.

Contrary to the outside world, prisoners usually do not find themselves in a situation where they can choose their health provider and are therefore fully dependent on the health care services available to them in the place of detention. In spite of international and national documents outlining medical ethics in places of detention, principles of medical ethics are at high risk of being violated in these places. Some of the more recent violations that became public and were widely discussed include force-feeding of hunger strikers by health care professionals in Guantanamo Bay⁵⁵ (see also the chapter on the handling of hunger strikes in this Section), participation of health care professionals in carrying out the death penalty in the USA⁵⁶, and complicity of health care professionals in torture in Guantanamo Bay.⁵⁷

Apart from these prominent examples, many subtle situations arise on a daily base, causing prison health professionals to breach the ethical standards of their profession. Examples of such situations are issuing certifications for the prison authorities that prisoners are fit for imprisonment or isolation, disclosing confidential medical data to the prison authorities without the informed consent of the prisoner, and not providing evidence-based treatment, as available in the community, to the prisoner due to financial or logistical reasons. Also the involvement of prison doctors in disciplinary measures and prison doctors treating both prisoners and prison staff, are ethical issues which may jeopardize the independence of the doctor towards the prison staff (see also the previous chapter in this Section on the role of the prison doctor and dual obligation dilemmas).

Medical ethics does not solely have to do with the independence of the prison health professional and inherent dual obligation issues (see the chapter on the role of the prison health professional and dual obligation dilemmas in this Section). Issues of medical ethics also include corruption (e.g. prison doctors only treating prisoners who pay them) and using prisoners as research objects in medical experiments or as organ donors.⁵⁸

54 PHR (2012). *Dual Loyalty and Human Rights. Guidelines for Prison, Detention and Other Custodial Settings*. Physicians for Human Rights, Boston, USA. Available at: <http://www.webcitation.org/getfile?fileid=cef65358623519e1a0cec3a-010408caf62b99469>

55 Annas (2006). Hunger strikes at Guantanamo – medical ethics and human rights in a 'legal black hole'. *N Engl J Med*. 2006;355(13):1377-1382. DOI: 10.1056/NEJMHle062316

56 Gawande (2006). When law and ethics collide – why physicians participate in executions. *N Engl J Med*. 2006;354(12):1221-1229. Available at: <http://www.nejm.org/doi/full/10.1056/NEJMp068042#t=article>

57 Iacopino and Xenakis (2011). Neglect of medical evidence of torture in Guantanamo Bay: a case series. *PLoS Med*. 2011;8(4):e10011027. Available at: <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001027>

58 Bagatell et al (2010). Organ donation by a prisoner: legal and ethical considerations. *The Journal of the Louisiana State Medical Society: official organ of the Louisiana State Medical Society* 162(1):44-6, January 2010. Available at: https://www.researchgate.net/publication/42587088_Organ_donation_by_a_prisoner_legal_and_ethical_considerations

In some developing countries, resources in terms of prison health staff members are so limited that the involvement of prisoners in the work of the clinic should be seen as a benefit for the patients. However, it will require specific precautions from the health professionals and the prison management to ensure medical confidentiality and respect for medical ethics. As stated by the Council of Europe, *'shortage of health care staff is no justification for involving imprisoned persons in health care tasks that require specialized training, even if they have medical qualifications, or as medical orderlies or in distributing medication'*.⁵⁹ In any case, arrangements must not imply that a prisoner working in the prison health clinic acquires any power that can be abused in the relationship with fellow prisoners.

Relevance to preventive monitoring

If medical ethics are not upheld by prison health professionals, this may in some cases amount to ill-treatment or even torture. This may happen if a prison health professional uses his/her medical knowledge and skills against the will of a prisoner and/or without an informed consent. This could for instance occur if the doctor is required to declare the fitness of a prisoner to any kind of punishment or to intervene in a hunger strike. Another example could be a health professional revealing confidential medical information to prison security staff.

Also using prisoners as research objects or as organ donors may amount to ill-treatment or torture. A clear example is forced organ harvesting from prisoners of conscience in China.⁶⁰

A prison health professional's complicity in torture, directly or indirectly, is of course always in violation with medical ethics.

International standards and guidance

Health care in places of detention is guided by the same medical ethical principles as those in the general community.

The four commonly accepted principles of medical ethics include:

- Principle of respect for autonomy
- Principle of nonmaleficence (do no harm)
- Principle of beneficence (do good)
- Principle of justice.⁶¹

The Mandela Rules stress (in Rule 32) that *'the relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards applicable to patients in the community'*. This includes that there is *'an absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation that may be detrimental to a prisoner's health, such as the removal of a prisoner's cells, body tissues or organs'* (Mandela Rules 32, 1(d)) and that *'without prejudice to paragraph 1(d) of this rule, prisoners may be allowed, upon their free and informed consent and in accordance with applicable law, to participate in clinical trials and other health research accessible in the community if these are expected to produce a direct and significant benefit to their health, and to donate cells, body tissues or organs to a relative'* (Mandela Rules 32, 2).

59 CoE (2019). *Organisation and management of health care in prison. Guidelines*. Council of Europe (Pont & Harding), 2019. Available at: <https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69>

60 See for statements and reports the website of the China Tribunal: <https://chinatribunal.com/>

61 Beauchamp and Childress (2008). *Principles of Biomedical Ethics* (Seventh edition published in 2013). Oxford University Press, 2013.

The eldest document requiring all physicians to uphold specific ethical standards is the Hippocratic Oath.⁶² As an update to the Hippocratic Oath, in 1948 the World Medical Association (WMA) adopted the Declaration of Geneva (last revision in 2006), which is a declaration of a physician's dedication to the humanitarian goals of medicine.⁶³

In 1975, the WMA adopted the Declaration of Tokyo, which comprises a set of international guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment, which was revised latest in 2016.⁶⁴ (see also the chapter on handling cases of alleged or suspected torture by the prison doctor).

In 1979, the International Council of Prison Medical Services agreed on the Oath of Athens, stating that *'we, the health professionals who are working in prison settings, meeting in Athens on September 10, 1979, hereby pledge, in keeping the spirit of the Oath of Hippocrates, that we shall endeavor to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics'*.⁶⁵

In 1982, the UN General Assembly adopted the 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 Punishment⁶⁶ which are outlined in box 7.

BOX 7:

THE 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

PRINCIPLE 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

PRINCIPLE 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.

(Continues)

62 See for the Hippocratic Oath: https://www.nlm.nih.gov/hmd/greek/greek_oath.html

63 WMA (1948, rev. 2006). *Declaration of Geneva*. World Medical Association, Geneva, 1948. Available at: <http://www.wma.net/en/30publications/10policies/g1/>

64 WMA (1975, rev. 2016). *Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*. World Medical Association, 2006. Available at: <http://www.wma.net/en/30publications/10policies/c18/>

65 International Council of Prison Medical Services (1979). *Oath of Athens*. International Council of Prison Medical Services, London, 1979. Available at: http://www.medekspert.az/ru/chapter1/resources/The_Oath_of_Athens.pdf
Gawande (2006). When law and ethics collide – why physicians participate in executions. *N Engl J Med*. 2006;354(12):1221-1229. Available at: <http://www.nejm.org/doi/full/10.1056/NEJMp068042#t=article>

66 UN (1982). *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations General Assembly, 1982. Available at: <http://www.un.org/documents/ga/res/37/a37r194.htm>

PRINCIPLE 3

It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.

PRINCIPLE 4

It is a contravention of medical ethics for health personnel, particularly physicians:

- (a) To apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments;*
- (b) To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.*

PRINCIPLE 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

PRINCIPLE 6

There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency.⁶⁷

Besides these international standards, a number of bodies have issued guidelines, rules and recommendations addressing medical ethics of health professionals working in places of detention, such as the Council of Europe with its publications on prison health care and medical ethics⁶⁸ and the organization and management of health care in prisons.⁶⁹ An example addressing religion in relation to medical ethics is the Islamic Code of Medical Ethics (Kuwait document), endorsed at the first International Conference on Islamic Medicine held in Kuwait in January 1981.⁷⁰ This Code includes several references to the Koran and statements by the Prophet. It also stresses the need that the '*physician should be amongst those who believe in God*' and that '*the role of Physician is that of a catalyst through whom God, the Creator, works to preserve life and health. He is merely an instrument of God in alleviating people's illness. For being so designated the Physician should be grateful and forever seeking God's help. He should be modest, free from arrogance and pride and never fall into boasting or hint at self glorification through speech, writing or direct or subtle advertisement*'.

Apart from international and regional ethical codes, most countries also have national ethical codes in place.

67 UN (1982). *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations General Assembly, 1982. Available at: <http://www.un.org/documents/ga/res/37/a37r194.htm>

68 CoE (2014). *Prison health care and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being*. Council of Europe, (Lehtmetts and Pont), Strasbourg, 2014. Available at: <https://rm.coe.int/prisons-healthcare-and-medical-ethics-eng-2014/16806ab9b5>

69 CoE (2019). *Organisation and management of health care in prison. Guidelines*. Council of Europe (Pont & Harding), 2019. Available at: <https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69>

70 IOMS (1981). *Islamic Code of Medical Ethics (Kuwait Document)*. Islamic Organization for Medical Sciences, 1981. Available at: <https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/islamic-code-medical-ethics-kuwait-document>

Monitoring methodology

The monitor should be aware of the risks that health professionals in places of detention face when it comes to upholding the principles of medical ethics. Monitoring medical ethics of the prison health service and individual prison health professionals should be seen in close relationship with monitoring the topics as described in the other chapters of this Section, as medical ethics underlies everything a prison health professional does. Besides the monitoring methodology described in those chapters, questions could be asked about (forced) organ donation and prisoners as research objects whenever these issues are relevant in the particular country/institution.

Further reading

International Council of Prison Medical Services (1979). *Oath of Athens*. Prison Health Care Practitioners, London, 1979. Available at: http://www.medekspert.az/ru/chapter1/resources/The_Oath_of_Athens.pdf

CoE (2014). *Prison health care and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being*. Council of Europe (Lehtmetts A, Pont, J), November 2014. Available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/Publications_HealthCare_manual_Web_A5_E.pdf

UN (1982). *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations General Assembly, 1982. Available at: <http://www.un.org/documents/ga/res/37/a37r194.htm>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

WMA (1948, rev. 2006). *Declaration of Geneva*. World Medical Association, Geneva, 2006. Available at: <http://www.wma.net/en/30publications/10policies/g1/>

WMA (1975, rev. 2006). *Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*. World Medical Association, 2006. Available at: <http://www.wma.net/en/30publications/10policies/c18/>

3.8. Medical confidentiality

Medical confidentiality is one of the core duties in medical practice. It requires health care providers to carry out medical examinations in private and to keep a patient's personal health information confidential, unless the patient provides informed consent to release the information (see also the next chapter on informed consent). Confidentiality is central to the preservation of trust between any health professional and his/her patient.

A breach of medical confidentiality occurs when medical examinations are carried out in presence of others than relevant health professionals and when a patient's private health information is disclosed to a third party without his or her informed consent. Legitimate exceptions occur for instance when required by law (e.g. when national security is at risk), or when there is a public interest (e.g. a threat to public health).

Although prison health professionals have the same obligations with regard to medical confidentiality as those working in the community, there are often conflicting interests because of their competing obligations to the prison authorities, making it sometimes challenging to strike the right balance between respecting their patients' confidentiality and protecting prisoners and staff.⁷¹

Relevance to preventive monitoring

If medical confidentiality is not upheld by prison health professionals, this may in some cases amount to ill-treatment. This could for instance happen if information about torture and ill-treatment is disclosed to the prison staff, leading to reprisals against the prisoner. Another example would be if the prison doctor discloses to prison staff that a prisoner is infected with HIV/AIDS, leading to stigmatization, social marginalization and/or harassment.

In 2009, the European Court for Human Rights received a complaint relating to a breach of medical confidentiality - in this case more specifically, confidentiality of medical correspondence. The case was found to be a violation of article 8 of the European Convention on Human Rights ('Right to respect for correspondence'):

Szuluk v. the United Kingdom 2 June 2009. The applicant suffered a brain haemorrhage while on bail. He had two operations before being discharged from hospital to prison to serve his sentence. Thereafter, he was required to attend hospital every six months for a specialist check-up. He discovered that his correspondence with the neuro-radiology specialist supervising his hospital treatment had been monitored by a prison medical officer. His complaint to the domestic courts was dismissed. Relying on Article 8 (right to respect for private and family life, and correspondence) of the Convention, the applicant complained that the prison authorities had intercepted and monitored his medical correspondence.

The Court held that there had been a violation of Article 8 (right to respect for correspondence) of the Convention. Noting that it was clear and not contested that there had been an "interference by a public authority" with the exercise of the applicant's right to respect for his correspondence, that was governed by law and was aimed at the prevention of crime and the protection of the rights and freedoms of others, it found however that, in the circumstances of the case, the monitoring of the applicant's medical correspondence had not struck a fair balance with his right to respect for his correspondence.⁷²

71 Elger B.S., Shaw D.M. (2017). *Confidentiality in Prison Health Care – A Practical Guide*. In: Elger B., Ritter C., Stöver H. (eds) *Emerging Issues in Prison Health*. Springer, Dordrecht, 2017.

72 ECHR (2019). *Factsheet – Prisoners' health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

International standards and guidance

International standards are clear in stating that prisoners have the right to medical confidentiality similar to persons living in the general community. However, violation of the right to medical confidentiality is more likely to have negative consequences for the patient in a place of detention.

The Mandela Rules state in Rule 31 that *'all medical examinations shall be undertaken in full confidentiality'*. In Rule 32, the Mandela Rules stress that *'the relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards applicable to patients in the community'*, among other issues referring explicitly to *'(c) the confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others'*.

In the seven essential principles for the practice of prison health care as set out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 'patient consent and confidentiality' is explicitly mentioned as a key aspect of prison health services.⁷³ Medical confidentiality for prisoners should be guaranteed and respected in the same way as for people living in the outside community.

The CPT standards state that prisoners should be examined individually and never in groups. Nobody else than the prisoner and medical professionals should be present during the examination. A security officer should not be in the same room and should stay out of hearing and out of sight during the medical examination, unless the medical professional requests otherwise due to safety and security reasons.⁷⁴

Physicians for Human Rights specify in their Guidelines for Prison, Detention and Other Custodial Settings that: *'the health professional should respect medical confidentiality; should insist on being able to perform medical duties in the privacy of the consultation, with no custodial staff within earshot; should divulge information strictly on a need-to-know basis, when it is imperative to protect the health of others'*.⁷⁵

The interests of the State sometimes outweigh the interests of the prisoners without a valid reason, leading to violations of prisoners' human rights including the right to medical confidentiality. This is not acceptable and should be a key focus of any monitor when visiting a place of detention.⁷⁶ There are, however, also valid reasons to breach a prisoner's right to medical confidentiality. This could for instance be the disclosure of information about a prisoner's TB diagnosis in order to identify contact cases and stop the dissemination of the disease, or the assessment that a prisoner has a severe personality disorder and is likely to violently injure other prisoners. The World Medical Association has provided guidance on conditions in which doctors' breaches in confidentiality may be considered. These include for instance when harm is believed to be imminent, serious and irreversible, and unavoidable except by disclosure without

73 The seven principles are: 1. Free access to a doctor for every prisoner, 2. Equivalence of care, 3. Patient consent and confidentiality, 4. Preventive health care, 5. Humanitarian assistance, 6. Professional independence, 7. Professional competence. Reference: https://www.unodc.org/documents/balticstates/EventsPresentations/FinalConf_24-25Mar11/Pont_25_March.pdf

74 CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.refworld.org/pdfid/4d7882092.pdf>

75 PHR (2002). *Dual Loyalty and Human Rights. Guidelines for Prison, Detention and Other Custodial Settings*. Physicians for Human Rights, Boston, USA. Available at: <http://www.webcitation.org/getfile?fileid=cef65358623519e1a0cec3a-010408caf62b99469>

76 CoE (2014). *Prison health care and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being*. Council of Europe (Lehtmet A and Pont J), November 2014. Available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/Publications_HealthCare_manual_Web_A5_E.pdf

consent, and greater than the harm likely to result from disclosure. Disclosure should contain only that information necessary to prevent the anticipated harm and should be directed only to those who need the information in order to prevent the harm. Also, the doctor should inform the patient about the disclosure of the information and explain the reasons why this was done. The patient's cooperation should always be sought. In case of doubt, the doctor should ask for expert advice.⁷⁷

The doctor should do everything possible to ensure that the patient is safe and that the patient's condition does not worsen because of the disclosure or in case of alleged torture, that he/she may experience torture again. It is clear that the circumstances under which the doctor may breach the patient's confidentiality are very limited.

With regard to prisoners' access to health care, they should have access to the prison health clinic without having to inform the prison staff about the reason. Also, the prisoner should not be asked and feel obliged to talk about the results of his/her medical examination afterwards.

In most places of detention, prison staff members are tasked with the distribution of medication to prisoners. In principle, prison staff should not have this task, as their role as medical support staff is problematic in terms of their position of power over prisoners. In cases where prison staff members are nevertheless tasked with the distribution of medicines, it is important that the medical staff pre-packs the medication without marking the type and dosage of the medication, but only with information about how and when the medication is to be taken, in order to preserve medical confidentiality.

Medical records and registers should be kept by the prison health service out of reach of others than the health professionals caring for the patients. Others, including prison management, prison guards and prisoners, must not have access. In the event a prisoner is transferred to another institution, the medical record should be sent in a confidential way to the prison health doctor in the receiving establishment or be given along with the prisoner.

In some countries, because of scarcity of prison health staff, some prisoners with or without health care training are used as supplementary helpers in the prison health clinic. Such pragmatic approach may be helpful to fulfill some basic needs, but it is a great challenge as to ensuring medical confidentiality. Prisoners helping in the prison health clinic should never be placed in a position of power over fellow-prisoners, which includes access to confidential health information (see also the chapter on medical ethics in this Section).

Monitoring methodology

The monitor should look into all sources of information when monitoring medical confidentiality in the institution.

The monitor should talk with the prison management about the general practices and procedures in the institution, for example with regard to handling of medicines and medical records, and should ask for examples where medical confidentiality has been breached.

Interviews with prisoners could give the monitor information on e.g. how they can get access to the prison health services and whether or not they would have to disclose health information to the prison guards in this process. Also, questions related to the distribution of their medication could be asked.

77 WMA (2015). *Medical Ethics Manual. 3rd edition 2015*. World Medical Association. Available at : https://www.wma.net/wp-content/uploads/2016/11/Ethics_manual_3rd_Nov2015_en_1x1.pdf

Prison health staff will be able to explain, inter alia, about the circumstances of medical examinations (out of sight and hearing of others?) and the handling of medication and medical records.

Interviews with prison guards should foremost concentrate on their role in gaining prisoners access to the prison health services and on their role in the handling and distribution of medicines.

Observations should focus on the way in which medication is provided to the prisoners, on how the physical surroundings of the offices in the health clinic are, and on how medical records are being kept.

The monitor should look for the existence of documents, such as written instructions related to upholding medical confidentiality. Also, medical records could be consulted to see whether they contain any information about breaches in privacy and conveying information to, for instance, the prison management about allegations of torture without informed consent of the prisoner, together with the doctor's reasoning for such breaches.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.ref-world.org/pdfid/4d7882092.pdf>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

3.9. Informed consent

Informed consent can be defined as the consent of a patient or other recipient of services based on the principle of autonomy. This has become a requirement at the center of morally valid decision making in health care, research and monitoring. Patients must in principle always give their informed consent to any medical intervention and examination. True consent requires proper information which should also take into account illiteracy, difficulties in understanding, and language barriers which are often found in the prison population.

In relation to prison health services, informed consent means that the health care professional shares all relevant information with a competent prisoner enabling him/her to make a voluntary choice to accept or refuse treatment or to allow the prison health professional to report confidential health information, including torture and ill-treatment, to others.

The term 'relevant information' means the doctor's assessment of the diagnosis or the necessary means to reach a diagnosis, the spontaneous course of the disease/condition, the nature of any examination and treatment options, the risks and side effects of examinations and treatment, the risk of non-treatment and the benefit from treatment.⁷⁸ If the doctor considers conveying information about torture or ill-treatment to higher authorities, the patient must always be informed about the risk of reprisals.

The doctor has the obligation to keep record of medical examinations and treatment, and to ensure confidentiality (see also the chapter on medical confidentiality in this Section). However, if for some reasons the records cannot be kept confidentially the doctor should in fact see the record as a way of conveying information about the person (including about any ill-treatment and torture). This creates an ethical dilemma, where notes which involve, or may result in, harm to the prisoner should be subjected to informed consent. In any case, the doctor's obligation to protect the well-being of his/her patient is more important than putting things on record.

Consent implies both choice and understanding. 'Consent' given under pressure is not consent. 'Consent' given without a reasonable understanding of treatment options, of the purposes for which information is to be processed, and of the type and purposes of the envisaged enclosures is also not valid. Health care professionals must work on the presumption that every adult has the capacity to decide whether to consent to an action, unless it is shown that they cannot understand information presented in a clear way.

Relevance to preventive monitoring

Every prisoner must be requested to give his/her informed consent for several actions as well as for disclosures of information. Obtaining informed consent and keeping good record is a way to ensure that the patient is treated as a person capable to make decisions about his/her own life, even when these decisions may imply risks. Reporting torture and ill-treatment may lead to reprisals, including further torture and ill-treatment, and a prisoner needs to be informed about this beforehand and give his/her informed consent to the reporting.

So, not asking a prisoner for his/her informed consent before disclosing information is not in itself ill-treatment or torture but disclosing information which may lead to harm, including torture and/or ill-treatment, without the informed consent by the prisoner is always unacceptable and unethical.

⁷⁸ CoE (Lehtmetts A and Pont J) (2014). *Prison health care and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being*. Council of Europe, November 2014. Available at: <https://rm.coe.int/publications-healthcare-manual-web-a5-e/16806ab9b5>

During visits to Germany and the Czech Republic, the European Committee for the Prevention of Torture (CPT) has raised questions regarding the use of surgical castrations of sexual offenders and have spoken strongly against this practice. One of the arguments has been that it is questionable whether consent to the option of surgical castration will always be truly and freely informed. CPT states that a situation can easily arise whereby prisoners acquiesce rather than consent, believing that it is the only available option to avoid indefinite confinement.⁷⁹ Similar concerns were raised regarding libido-suppressing treatment (chemical castration) of sexual offenders in Denmark.⁸⁰

International standards and guidance

Rule 32 of the Mandela Rules states that *'The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community'*, including *'adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship'*.

The European Committee for the Prevention of Torture states in its CPT Standards, Standard 41, that: *'Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorizing treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances'*.

The CPT Standards 45-47 state: *'Freedom of consent and respect for confidentiality are fundamental rights of the individual. They are also essential to the atmosphere of trust which is a necessary part of the doctor/patient relationship, especially in prisons, where a prisoner cannot freely choose his own doctor. Patients should be provided with all relevant information (if necessary, in the form of a medical report) concerning their condition, the course of their treatment and the medication prescribed for them. Preferably, patients should have the right to consult the contents of their prison medical files, unless this is inadvisable from a therapeutic standpoint. They should be able to ask for this information to be communicated to their families and lawyers or to an outside doctor. Every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole'*.

The UN Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the "Istanbul Principles") outline in Principle 6(a): *'Medical experts involved in the investigation of torture or ill-treatment shall behave at all times in conformity with the highest ethical standards and, in particular, shall obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice'*.⁸¹

Prisoners keep their rights to receive medical information and the option to accept or refuse examination and treatment. It is important that health professionals identify themselves to their

79 CPT report of visit to Germany in 2010: <http://hudoc.cpt.coe.int/eng?i=p-deu-20101125-en-42>
CPT report of visit to Czech Republic in 2008: <http://hudoc.cpt.coe.int/eng?i=p-cze-20080325-en-16>

80 CPT report of visit to Denmark in 2008: <http://hudoc.cpt.coe.int/eng?i=p-dnk-20080211-en-28>

81 UNOHCHR (2000). *The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations Office of the High Commissioner on Human Rights, General Assembly resolution 55/89 of 4 December 2000. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/EffectivelyInvestigationAndDocumentationOfTorture.aspx>

patients, explain the purpose of the examination or treatment, and make sure that prisoners are aware that they have a choice to accept or refuse.

There are some exceptional circumstances which permit an intervention without consent – and this in fact applies to prisoners as well as persons in the outside community. These are when patients are judged mentally ill, incompetent to make a decision, and a danger to themselves or other people. If they are judged to be mentally ill and unable to understand their condition with its inherent danger to themselves or others, prisoners should be treated on the same terms as other mentally ill patients in the outside community and in conformity with the law. This may imply transfer of the person to a closed psychiatric department and treatment without consent, according to applicable law. However, before taking such decision every effort must be made to try to make the patient understand the situation and the consequences of not accepting necessary treatment. More on mentally ill prisoners is outlined in the chapter on mental health problems in Section 5.

A prisoner may address the prison health service because of traumatization, to have treatment and/or to have his/her lesions documented. The doctor should inform that he/she in any case has to make a (confidential) report and should – with informed consent - a) ask about the origin of the lesions, b) make a physical examination, and c) if torture or inter-prisoner violence is the alleged origin of the lesions, ask for another informed consent allowing him/her to report it. Information in this connection means explaining the procedures for reporting and the consequences – positive as well as negative – that this may have for the prisoner, including the risk of reprisals from staff members and fellow prisoners who may be accomplices in torture or may have assaulted the patient. The requirement of obtaining informed consent means that the patient at all three stages has the right to refuse cooperation, fully or partially.

As outlined in the chapter 'Interviewing for monitoring purposes' in Section 2, also monitors should adhere to obtaining informed consent, by asking the interviewee explicitly whether he/she wishes to participate in an interview (*first informed consent*). After the interview, the monitor should ask for *second informed consent* for using the obtained information. No personal details, including any information that could identify the interviewed person, may be published or handed over to anybody outside the monitoring team without the expressed consent of the interviewed person. In addition to informed consent, the monitoring team should endeavor to ensure that publishing or handing over information from interviews does not expose the interviewed person to any risk of reprisals, even if the person has given his/her informed consent. Hence, it may happen that personal information cannot be released for safety reasons.

Monitoring methodology

When monitoring the way in which prison health professionals adhere to their obligation to ask their patients for informed consent, the monitor will get most information from interviewing prisoners, interviewing prison health staff and reviewing written instructions and medical records.

Interviews with prisoners will for instance be able to give information about whether they have been asked for informed consent when information about their health was being disclosed. They could also be asked whether they are aware that they have the right to accept or refuse medical examination or treatment.

Prison health staff should be asked how they apply the principle of informed consent for medical examinations, reporting, and disclosure of confidential health information. A question could for instance be whether they were ever informed about torture or ill-treatment by a prisoner and

if yes, how they acted, including whether they asked the prisoner for informed consent before documenting anything.

Documents should be consulted during the monitoring visit. For instance, the monitor should look whether there are written instructions to prison health staff on the issue of asking for informed consent. Medical records could give the monitor an indication about whether prisoners had been asked for their informed consent prior to a medical examination/treatment and prior to disclosing confidential health information.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CPT (2010). *CPT Standards 2002, revision 2010*. Standards 45-47. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.refworld.org/pdfid/4d7882092.pdf>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UNOHCHR (2000). *The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations Office of the High Commissioner on Human Rights, General Assembly resolution 55/89 of 4 December 2000. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/EffectiveInvestigation-AndDocumentationOfTorture.aspx>

3.10. The role of the prison health professional in alleged and suspected cases of torture

Given their profession and tasks, health professionals are in a key position to discover if torture and/or ill-treatment takes place in a place of detention. Especially those working in places of detention have an important role, as they would be the ones most often encountering persons who allege to have experienced torture or ill-treatment, or persons for whom the health professional suspects this.

Most places of detention have a health clinic in place, or at least a doctor or other health professional on call in case needed. As discussed extensively in the chapter on the role of the prison health professional and dual obligation dilemmas in this Section, prison health professionals working in places of detention may have conflicting obligations and responsibilities due to the circumstances of their employment, especially when employed by the prison administration. However, as also outlined in the chapter on medical ethics in this Section, no matter the conditions of employment of a health professional working in a place of detention, his/her fundamental duty is to act in the best interest of his/her patient, i.e. the prisoner.

Prisoners may present to the prison health professional with allegations of torture and/or ill-treatment or the health professional may have a suspicion that the prisoner has experienced torture/ill-treatment based on his/her symptoms and/or physical injuries. This will most often be during the initial medical assessment but may also occur later during detention. Prisoners could present to the health professional soon after the torture/ill-treatment or months/years later, when physical injuries may no longer be visible. In some cases where the prison health professional may suspect torture/ill-treatment, the prisoner may have died (see also the chapter on deaths in custody in Section 5).

Assessing an alleged or suspected case of torture/ill-treatment is based on the health professional's skills and knowledge and entails potential benefits as well as risks to the prisoner.

Relevance to preventive monitoring

Torture and ill-treatment are crimes committed by or with the acquiescence of state officials or persons acting in a public capacity. Attempts may be made to cover up these crimes by threatening victims with additional torture/ill-treatment if they reveal any information about it to others, including health professionals.

In case a victim chooses to inform a health professional, he/she has the choice to either document and report the case or to not do so. A health professional who does not document and report an alleged or suspected case of torture/ill-treatment is acting contrary to his/her duty to do so (as outlined in several international standards, as presented below). This may make him/her passively complicit in torture/ill-treatment, as he/she is hiding what has happened.⁸²

An example is the neglect of medical evidence of torture in Guantanamo Bay. A research showed that medical records were thorough when it came to regular health problems, but that medical professionals failed to inquire about or document the cause of those physical and mental symptoms that suggested possible torture (in a study of 9 cases). *'The medical doctors and mental health personnel who treated the detainees at GTMO (Guantanamo) failed to inquire and/or document causes of the physical injuries and psychological symptoms they observed. Psychological symptoms were commonly attributed to "personality disorders" and "routine stressors of*

82 See for an example: <https://www.bbc.com/news/uk-england-20809692>

confinement.” Temporary psychotic symptoms and hallucinations did not prompt consideration of abusive treatment.’⁸³

While neglecting or ignoring possible signs of torture/ill-treatment by a medical professional is ethically unacceptable, also documenting and reporting a case of torture/ill-treatment may in some cases be problematic. It may lead to reprisals and additional torture/ill-treatment for the concerned prisoner, which would not be in the prisoner’s best interest and would violate the ethical principle of ‘do no harm’. The health professional may therefore consider not to document and report the case. This makes it clear that the prison health professional faces a difficult dilemma and both documenting and reporting, and not doing so, may have negative consequences for the prisoner.

International standards and guidance

There are a number of international standards, reports and guidance documents which are of specific relevance to the role of the prison health professional in alleged and suspected cases of torture and/or ill-treatment. These include:

- The UN 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 (1982).
 - The WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (2007).
 - The UN Mandela Rules (2015)
 - 23rd General Report of the European Committee for the Prevention of Torture (2013).
 - The UN Istanbul Protocol (2004)
- (See references of all under further reading)*

The standards clearly state that health professionals have a moral duty to protect the physical and mental health of detainees.

The UN Principles of Medical Ethics state in Principle 2 that *‘it is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.’*

‘Complicity in’ may include covering up a case of torture/ill-treatment when presented to the health professional (either alleged or suspected).

The WMA Resolution highlights the duty of physicians to document and condemn acts of torture and ill-treatment and states indeed that a failure to do so constitutes complicity in such abuse. It also recommends that national medical associations *‘attempt to ensure that physicians include assessment and documentation of symptoms of torture or ill-treatment in the medical records using the necessary procedural safeguards to prevent endangering detainees’.*

The Mandela Rules state in Rule 30 that *‘A physician or other qualified health-care professionals, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary’* and that,

83 Iacopino & Xenakis (2011). Neglect of Medical Evidence of Torture in Guantánamo Bay: A Case Series. *PLOS Medicine*, April 2011. Available at: <https://doi.org/10.1371/journal.pmed.1001027>

among other things, particular attention should be paid to: *'Identifying any ill-treatment that arriving prisoners may have been subjected to prior to admission.'*

Furthermore, the Mandela Rules require in Rule 34 that, if healthcare professionals *'become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm.'*

Also the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) requires health professionals working in places of detention to document and report medical evidence of torture and ill-treatment, as stated in the 23rd General Report of the CPT.

There is however a key ethical dilemma that prison health professionals may face when encountering a suspected or alleged case of torture/ill-treatment. This is outlined in the Istanbul Protocol, where it states in paragraph 68 that: *'In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaking the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters.'*

Other prison health professionals, such as nurses, have the same ethical obligation to identify, document and report torture/ill-treatment. This is for instance stated in the Position Statement on nurses' role in the care of detainees and prisoners, published by the International Council of Nurses in 2011: *'Nurses who are aware of abuse and maltreatment should take appropriate action to safeguard the rights of detainees and prisoners.'*⁸⁴

There is a difference between cases where a person alleges to have experienced torture or ill-treatment and those where the health professional has a suspicion only. The difference lies in the way the health professional should approach the person. In cases of suspicion only, the health professional should always approach the topic slowly and carefully in order not to upset the person and/or to discourage the person to talk about what he/she may have experienced. In cases of alleged torture, the health professional could easier jump to detailed questions.

As addressed in the Istanbul Protocol (see above), a health professional's duty to report and document may be conflicting with his/her ethical obligations to respect the autonomy and privacy of a patient and to do no harm. In general, it can be stated that the best interest of the patient always prevails over the health professional's duty to document and report. This does, however, not mean that the best interest of the patient should be an excuse for doing nothing. The health professional should always consider all options and consider 'doing nothing' only as a last resort.

84 ICN (2011). *Nurses' role in the care of detainees and prisoners, position statement*. International Council of Nurses, 2011. Available at: https://www.icn.ch/sites/default/files/inline-files/A13_Nurses_Role_Detainees_Prisoners.pdf

Informed consent should be sought and well-documented at the outset of all clinical assessments of alleged or suspected torture/ill-treatment (see also the chapter on informed consent in this Section). Informed consent requires that the prisoner understands the information provided and that he/she provides consent voluntarily. The autonomy of prisoners who refuse to provide informed consent for an assessment should always be respected and nobody should ever be forced to comply against his/her will.

The duty of the prison health professional to treat medical information confidentially, may only be superseded with the informed consent by the prisoner (except in cases where disclosure is essential for public health requirements, such as is the case with certain infectious diseases). One could, however, think of very exceptional circumstances where it would be justified for the health professional to breach confidentiality without the patient's consent. These could for instance include that severe or life-threatening harm to others is fairly certain to occur if no action is undertaken.

Prison health professionals are likely to observe evidence of patterns of torture/ill-treatment and may therefore consider reporting anonymous information, which would prevent potential harm to others. Information that is not person-attributable could be used for this purpose (collection of data about patterns of torture). However, it is of paramount importance that the confidentiality of such data is ensured.

Monitoring methodology

When monitoring the role of the prison health professional in alleged and suspected cases of torture or ill-treatment, the monitor should foremost concentrate on interviews with prison health staff and prisoners and look into any available documentation. Prison management may be able to give some information, while prison guards cannot be expected to be able to give much useful information to the monitor about this aspect.

When interviewing the prison management, the monitor could for instance ask whether a prison health professional has ever informed them about a case of torture/ill-treatment and if yes, how this information was handled.

Interviews with prisoners are mostly useful if the monitor gets to speak to prisoners who allege to have experienced torture and/or ill-treatment in this or a previous institution. The monitor could then ask whether or not the prisoner talked about this to the health professional in the institution and what happened next.

When interviewing prison health staff, the monitor should investigate whether they have ever come across prisoners who alleged to have experienced torture or ill-treatment and/or whether they have had suspicions that a prisoner may have experienced this. The monitor could ask into the procedure that was followed, whether the case was documented and reported and whether the prisoner was asked for informed consent at several points during the procedure.

Finally, the monitor could look into any available documentation, for instance guidelines and medical records of prisoners who state to the monitor to have experienced torture or ill-treatment.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

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3.11. Medical records and health information system

The prison health system is subjected to a requirement of equivalence of care, indicating that the care inside the prison should match the care in the outside community. The principle of equivalence of care has been addressed in the respective chapter in this Section. Equivalence of care does not only apply to the qualifications of the health care staff and the access to medicines and treatment procedures in the prison, but also to procedures for recording of medical information (medical record-keeping) and systems of health information.

The record-keeping comprises the following features:

- Which information is recorded about patients, consultations, prescriptions and tests?
- Who can record information in the medical files?
- Can recorded information be changed afterwards?
- How are the records stored (applies to both paper-based and digitalized records)?
- Who can access the medical records, and what are the procedures for doing so?
- Are records common across institutions or shared across institutions?
- Can records follow the prisoners upon their release?
- If records do not follow the prisoner, are they stored in such a way that they can later be retrieved upon request from other health professionals who have the consent of a patient?

A derived benefit of good record-keeping – especially of electronic record-keeping – is the possibility of establishing a health information system, either for the single institution or for the prison health system as a whole. Such a system may provide information at the population level (statistics) about the state and development of health and health care provision indicators in the prison population. A health information system may, inter alia, be used for monitoring the spread of disease in the institution, prompting preventive measures to intercept an epidemic, or to change or strengthen the diagnostics included in the initial medical assessment (see also the chapter on the use of numbers in monitoring health in places of detention in Section 2).

Relevance to preventive monitoring

Sub-standard medical record keeping may have several consequences. In some prison systems, the prison health care service only keeps a common book comprising one line (date, name and prescription) for each individual consultation. Such poor recording does not promote any overview of the health situation nor the care the prisoner has received. In fact, poor records may jeopardize patient care and lead to serious incidents, i.e. jeopardizing the quality and acceptability of the health care.

Further, the administration of access to the medical records may involve the risk of breaching medical confidentiality, for instance, in case prison guards have access to the content.

There are many examples of poor record keeping in countries worldwide. One example is reflected in the report of the European Committee for the Prevention of Torture (CPT) after its visit to Ireland in 2010:

'Paragraph 67: The CPT's delegation noted that the quality of the medical records remained in too many instances inadequate. In general, the doctors' notes were scant while the nurses' notes were much more comprehensive. In Cork Prison, the records were in a state of confusion and doctors' consultations with prisoners there as well as at Midlands and Mountjoy Prisons often took place without having the benefit of the paper medical records to hand, which include copies of hospital results and letters. Also, at these prisons there was a lack of disease registers and summaries

*of past medical histories within the medical notes, as well as a paucity of information generally in the notes. Moreover, there was a failure to record the findings of each health-care consultation episode within the notes’.*⁸⁵

In 2003, Anaraki et al. conducted a research on the prison health information system in four prisons in the UK and found that *‘Prisoner medical records are kept on paper files known as inmate medical records or IMRs. None of the prisons we visited had computerised primary care information systems. Medical records consist of handwritten notes that are sometimes barely legible. In some cases, such as patients with multiple pathology or chronic conditions, these paper records could consist of several large volumes. The files include all clinical information, including GP notes, psychological and other referral reports, test results, prescriptions and drug administration charts. Retrieving relevant and accurate information on individual inmates during consultations could be difficult, time consuming or, in certain cases, even impossible.’*⁸⁶

While a breach of standards for medical record-keeping in itself does not imply torture or ill-treatment, the way records are kept may, however, reflect medical complicity in torture or ill-treatment (by covering up cases of torture or ill-treatment), a breach of medical confidentiality, or a breach of the principle of equivalence of care.

The possibility to change recorded information in the medical records is of paramount importance when the records play a role in human rights violations, e.g. torture or ill-treatment. If changes are possible and not logged as changes, it is possible for the doctor (or maybe even someone else) – possibly under pressure – to remove or alter evidence of violence, abuse, torture or ill-treatment. Such removal or alteration may imply that the possibility of the victim of torture or ill-treatment to get justice, is eliminated.

BOX 8:

CASE EXAMPLE DANISH NPM

During a monitoring visit in Denmark, a doctor in the monitoring team encountered a foreign prisoner complaining about police brutality immediately before his arrival at the pre-trial detention some months earlier. The police brutality included neck locks and threats, allegedly leaving bruises. According to the prisoner, he asked for a medical examination few days after his arrival to the pre-trial detention but was only seen by the doctor three weeks after he was admitted.

The health service (a practicing GP with a second job in the pre-trial detention) was asked to provide the medical record for possible triangulation of the information from the prisoner. The record system, however, was developed by the GP and consisted of a Word-based single standing system, where only the GP had access. Thus, whatever was present in the medical record, it might easily have been changed before submission to the monitoring team.

Access to electronic medical records and to computerized health information systems in prison health is rare. Technology is often lagging behind the general health care system. A lack of electronical health information systems is a major obstacle in the provision of adequate health care to prisoners.⁸⁷

85 CPT (2011). *Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*. CPT, Strasbourg, 2011. Available at: <https://rm.coe.int/1680696c98>

86 Anaraki et al. (2003). ‘Delivering Primary Care in Prison: The Need to Improve Health Information’. *Journal of Innovation in Health Informatics* 11(4):191–94. Available at: <https://hijournal.bcs.org/index.php/jhi/article/view/566/578>

87 Anaraki et al. (2003). ‘Delivering Primary Care in Prison: The Need to Improve Health Information’. *Journal of Innovation in Health Informatics* 11(4):191–94. Available at: <https://hijournal.bcs.org/index.php/jhi/article/view/566/578>

In case there is no health information system in place, the health service authorities will not know if an apparent increase of a disease (e.g. tuberculosis) is due to import of cases or spread within the institution. As mentioned previously, the contraction of a serious disease during a stay in a place of detention may amount to ill-treatment and should be prevented (see also the chapter on communicable diseases in Section 5).

International standards

The standard of keeping individual and accurate up-to-date medical files is represented in the Mandela rules, Rule 26. Here it is further stressed that all prisoners should have access to their medical file, possibly through a third party (lawyer, relative etc.). Continuity of care is also to be secured through a standard of transferring medical records with the prisoner, when he or she is moved to another institution. In addition, Mandela Rule 7 outlines that upon admission of a prisoner in an institution, information shall be entered into the prisoner file management system, including information on *'any visible injuries and complaints about prior ill-treatment'*.

The European Prison Rules are less articulate about the requirements of a health information system, but stress in Rule 43 that medical records should only be disclosed to others with the written authorization of the prisoner.

In addition to these human rights based international standards, international research addresses medical record keeping in prisons and in general. While such research results may not be characterized as setting international standards, they nevertheless make up good practices which may find use as standards guiding the preventive monitoring and recommendations issued. Also, some countries have specific laws stipulating the duties of health professionals in places of detention in relation to record keeping. Often, the prison health care system is a separate system, neither integrated into nor smoothly interacting with the general public health care system but managed separately by the ministry responsible for the administration of the prison system. This separation may imply that systems, rules and procedures applying to the general health care system, do not necessarily apply to the prison health care system. Examples may include an electronic patient journal (e-medical record), and systems for referral to specialists and lab-tests including receiving results of these referrals.

Monitoring methodology

The health monitor has an important role in monitoring medical record keeping and the health information system in the institution. It has to be stressed that it is not the role of the monitor to review the quality of the medical treatment provided and reflected in the records. An exception to this rule may be if there are numerous indications that the quality in general is sub-standard, with a risk to the health of prisoners.

When monitoring medical records and health information systems, the health monitor should foremost concentrate on interviewing prison health staff and looking into the health information systems that may be in place in the institution.

When interviewing prison health staff, the monitor could for instance ask which information is recorded about patients, consultations, prescriptions and tests, who can record information in the medical records and who can access or change this afterwards. The health information available to the prison health service may be reviewed by asking about health statistics at the prison population level, such as how many detainees are currently taking psychotropic drugs, how many prisoners have a hepatitis C diagnosis and how many new cases of tuberculosis has the prison diagnosed last year.

Prisoners may be able to give some information about their medical record, such as whether it was started upon their entry into the institution and whether they have insight into it.

Prison guards could be asked whether they have access to the prisoners' medical records and if yes, under what circumstances, while prison management could elaborate on their role (if any?) in the health information system in the institution.

When looking into documents, this includes foremost medical records, registers and any written instructions that may be in place. Medical records may be reviewed in general, with a focus on record-keeping. Selection of records for a general review of record-keeping may take place on a random basis and should include a review of:

- Format (paper-based, digitalized)
- Structure (built-up, sections)
- Access (which staff may read or write)
- Storage including data security / confidentiality
- Exchange with other (health) services
- Quality /accuracy
- Up-to-dateness

In addition, individual medical records may be selected and reviewed with a view to triangulation, to evaluate health-related events reported from other sources. Events to be triangulated with the medical records may be accounts by prisoners of contact with the prison health service or events surfacing as part of violent events accounted for by staff or management, or events connected to disciplinary measures or use of force.

The general review of medical records may, in addition to the aspects of record-keeping mentioned above, also provide information about:

- The initial medical assessment: How soon after arrival was it carried out? By whom? What was addressed and recorded?
- Occurrence and treatment of injuries: Are the causes of injuries addressed?

The monitor could also assess whether and how the prison health service keeps registers on specific diseases and whether any written instructions on record-keeping exist.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

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3.12. Handling of medicines

Considering that the prison population, on average, has a higher prevalence of both physical and mental health diseases and increased needs for treatment and care as compared to the general population, securing access to relevant medicines and the safe and careful handling of medicines is an important task of any prison health service.

The typical prison health service must handle considerable numbers and types of medicines on a daily basis. Some places of detention have their own pharmacies from which medicines are dispensed to the prisoners. In this case, supervision by an external pharmacist may be required to ensure proper stock-keeping and disposal of outdated medicine. In other places, medication is supplied on a named patient basis from a pharmacy in the general community. Often, places of detention also have a 'stock room' where commonly prescribed medications are stored.

Relevance to preventive monitoring

Medication errors are frequent and present a major public health burden.⁸⁸ This is possibly no less true for the handling of medicines in places of detention, even though very little research exists on this topic, and in some contexts the institutions are exempt from the general reporting requirement of adverse events in the health care system.⁸⁹

Failure to ensure proper handling of medicines in a prison may have serious consequences for the person and may amount to ill-treatment. For example, medication errors (e.g. wrong dosage given, wrong substance given), discontinuation of treatment due to lack of stocks, or the distribution of drugs that became inferior due to improper storage may very well lead to progression of disease, causing unnecessary suffering and in worst case implying a threat to the life of the person.

Prison guards and sometimes even prisoners may be involved in distributing medicines inside a prison. This causes serious issues with regard to the confidentiality of medical information, and in worst-case scenario may put a prisoner in danger, e.g. if he/she has a condition that is highly stigmatized inside the prison, like HIV, or if his/her treatment with sex hormones gives away information about him/her being transgender. Also, if medicines are not safely stored or the administration of medicines to prisoners is done in a way that enables them to sell them to others, medicines become a commodity that may give rise to conflicts between prisoners and even between guards and prisoners.⁹⁰ This in turn may lead to episodes of violence.

Forcibly administering medicine to a prisoner may constitute a violation of Article 3 of the European Convention on Human Rights ('No one shall be subjected to torture or to inhuman or degrading treatment or punishment') as illustrated by the following example:

Jalloh v. Germany 2006. The applicant was forcibly administered an emetic in order to cause him to regurgitate a small bag of drugs he had swallowed just before he was arrested.

The European Court on Human Rights observed that the Convention did not, in principle, prohibit recourse to a forcible medical intervention that would assist in the investigation of an offence. However, any interference with a person's physical integrity carried out with the aim of obtaining evidence had to be the subject of rigorous scrutiny. In the applicant's case the forcible administration

88 See the website of the European Medicines Agency: <https://www.ema.europa.eu/en/human-regulatory/post-authorisation/pharmacovigilance/medication-errors>

89 See Denmark as an example : <https://www.retsinformation.dk/pdfPrint.aspx?id=134522>

90 Douglas Del Paggio (2012). Psychotropic medication abuse by inmates in correctional facilities. *Mental Health Clinician*: February 2012, Vol. 1, No. 8, pp. 187-188. Available at: <https://doi.org/10.9740/mhc.n95631>

of emetics did not appear to have been indispensable and the manner in which it was executed was brutal. Such treatment was found to be inhuman and degrading, in breach of Article 3 of the Convention.⁹¹

International standards and guidance

International standards are limited when it comes to the handling of medicines in places of detention, but what they have in common is that they state that prisoners should never be involved in the distribution of medicines.

The Mandela Rules state in Rule 67 (4): *'If a prisoner brings in any drugs or medicine, the physician or other qualified healthcare professional shall decide what use shall be made of them'*.

As outlined by the Council of Europe in its manual on prison health care and medical ethics:

'The involvement of inmates in a prison's healthcare service should be seen as a last resort, even when they have medical qualifications. Prisoners should not be involved in the performance of healthcare tasks that require specialized training, and under no circumstances should they perform the distribution of medicines'.⁹²

The American Bar Association published the third edition of the ABA Standards for Criminal Justice – Treatment of Prisoners in 2011, which explicitly addresses the control and distribution of prescription drugs in Standard 23-6.3:

'A correctional facility should store all prescription drugs safely and under the control and supervision of the physician in charge of the facility's health care program. Prescription drugs should be distributed in a timely and confidential manner. Ordinarily, only health care staff should administer prescription drugs, except that health care staff should be permitted to authorize prisoners to hold and administer their own asthma inhalers, and to implement other reasonable "keep on person" drug policies. In an emergency, or when necessary in a facility in which health care staff are available only part-time, medically trained correctional staff should be permitted to administer prescription drugs at the direction of qualified health care professionals. In no instance should a prisoner administer prescription drugs to another prisoner'.⁹³

Handling of medicines in a place of detention implies that different types of medicines need to be ordered, stored, and distributed to patients, and disposed of in the safest ways possible. At the same time, considerations may be required on how to act in the most cost-effective way when purchasing stocks and on how to ensure that there is low potential for misuse and theft.

Ordering medicines in a place of detention requires that the staff responsible is at all times aware of the stocks and of the time when medicines may expire or run out, so that there is no risk of using medicines that are out of date and no risk of stocks becoming depleted before new stocks arrive. Keeping a register of the inflow and outflow of medicines may therefore be necessary. Also, the conditions under which medicines are stored are important. For instance, some medicines need to be stored at low temperatures and may lose effect if they are not stored correctly.

91 ECHR (2019). *Factsheet – Prisoners' health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

92 CoE (Lehtmetts A and Pont J) (2014). *Prison health care and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being*. Council of Europe, November 2014. Available at: <https://rm.coe.int/publications-healthcare-manual-web-a5-e/16806ab9b5>

93 ABA (2011). *ABA Standards for Criminal Justice. Treatment of Prisoners. Third edition*. American Bar Association, Washington, 2011. Available at: http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/Treatment_of_Prisoners.authcheckdam.pdf

Distributing medicines to prisoners implies assuring the right drug, in the right dose, to the right patient, at the right time. This involves detailed record keeping, starting with the doctor's prescription of a drug to a certain prisoner followed by keeping record of every time a drug is handed out to the prisoner. Also, it implies keeping record of any deviations from the prescription including the reason for the deviation and keeping record of any adverse effects of the medication.

In some places of detention, prisoners are allowed to keep their own medicines in the cell, but more often a directly observed treatment scheme is used to avoid misuse, sale and theft. Especially strict rules may apply to controlled substances like methadone. Also, special and less strict rules may apply to over-the-counter medicines, natural medicinal products and vitamin and mineral products.

In institutions with many prisoners on medication, distributing medicines may be a task requiring a lot of the health staff's time. In some instances, for instance if health staff is not present in the institution around the clock, prison guards may be involved in the handing out of medicines. This may be efficient, however causes several challenges because prison guards are not necessarily trained for this task. Also, by being directly involved in the prisoner's health care, they may obtain information that would otherwise be confidential (e.g. handing out antiretrovirals would give away the information that a prisoner is infected with HIV). The same is of course the case if prisoners are involved in the handling of medicines, which they should never be.

Dispensing medicines to prisoners also implies securing the supply for prisoners going on leave and for those leaving the prison for other reasons, e.g. transfer to another institution or release, at least until they have had time to make arrangements with other health providers or until their treatment has been finalized.

Monitoring methodology

A monitor should look into the procedures and practices of the institution with regard to ensuring that necessary medicines are available in the prison, that medicines are safely and adequately stored, disposed of and distributed, and that prisoners receive the right medicines in the dosages and at the times prescribed by the doctor.

The monitor should ask the prison management about the general situation in the institution with regard to the handling of medicines and whether the institution has specific guidelines/instructions relating to the handling of medicines, including guidance and instructions received from the country's Ministry of Health, Medicines Agency or Patient Safety Agency on for instance the handling of accidents/errors in relation to medicines and prisoners' complaints about medication.

Interviews with prisoners will be very useful in gaining insight into prisoners' experience with the handling of medicines in the institution, for instance whether the prisoner could continue any treatment/medications he/she received before his/her imprisonment, whether he/she receives treatment in the dosage and at the intervals prescribed by the doctor and whether he/she has experienced any medication errors. The prisoner could also be asked who is in charge of delivering the medicines to him/her.

Prison health staff will be able to inform the monitor about the daily practice and any instructions/guidelines there may be to guarantee the safe and appropriate handling of medicines. The monitor could for instance ask the prison health staff about whether they can ensure sufficient stocks of medicines, about who is in charge of the pharmacy, and about their role in dispensing and delivering the medicines to the prisoners.

Prison guards can be asked about their role in delivering medicines to the prisoners and the training they may have received prior to being able to do so. They could also be asked what they do in case of a medication error or in case a prisoner is in acute need of medication, for instance because he/she has a prescription of a PRN drug, i.e. a drug taken only when needed (e.g. treatment for a migraine attack or intermittent other pain).

During the monitoring visit, the monitor may observe the pharmacy of the institution, including for instance whether medicines are kept well in order and separately from other things, whether the room looks tidy and clean, and whether there are any expired drugs on the shelves. He/she may also observe the actual handing out of medicines to prisoners to see whether this takes place in a safe way and in compliance with the guidelines of the institution.

Finally, the monitor should consult any relevant documentation available to him/her, which could give more insight into how the institution handles medicines. These could for instance include written instructions, register on stocks of medicines, and documentation used when giving out medicine to a prisoner.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

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3.13. Handling of hunger strikes

A hunger strike can be defined as a method of resistance or pressure in which a person does not eat for a significant amount of time, with the aim of achieving a specific goal.⁹⁴ Hunger strikes are most often undertaken by people who lack other ways of making their demands known. They may involve total fasting or partial fasting, where partial fasting refers to hunger strikes where protesters still take some form of nutrition. It is important to keep in mind that the consequences of these different forms of fasting may be the same. The hunger striker may be just as committed and determined to continue, and the results of the fasting may be just as fatal. In some exceptional cases, the hunger striker does not only not eat but does not drink either, which can be referred to as a dry hunger strike.⁹⁵

A person on hunger strike could nevertheless be fed. This is mostly done by artificial feeding, force-feeding or more rare, rectal feeding.

Artificial feeding refers to feeding (intravenously or by way of a gastric tube), whether or not upon request by the person, and with or without the consent of the person (expressed previously or at the moment of feeding). Hunger strikers might accept some form of artificial feeding, such as intravenous saline solution infusions or certain vitamins and minerals.⁹⁶

Force-feeding refers to a form of artificial feeding imposed on a person against the will or expressed wishes of the person, thus involving coercion.⁹⁷ Force-feeding is never ethically acceptable during hunger strikes.⁹⁸

Rectal feeding ('nutrient enema') refers to inserting a tube into a person's rectum with the intent of providing nutrition. Rectal feeding of a person on hunger strike is never ethically acceptable.

Hunger strikes in places of detention are relatively common in certain countries, but fortunately most of the time without severe consequences for the health of the involved persons. The reasons why prisoners decide to fast vary and range from reasons such as protesting against the regime in the place of detention, protesting against a punishment such as isolation, and higher moral, political or philosophical considerations. Hunger strikes can be carried out by individual prisoners or by groups of prisoners. Some recent examples of mass hunger strikes are the mass hunger strike of about 1.800 Palestinian prisoners in Israel in 2012 and the mass hunger strike of over 29.000 prisoners in California, USA, in 2013. In places where prisoners' basic human rights are not (fully) respected, hunger strikes are often perceived as a last resort for prisoners to protest and to be heard.

94 Irmak, N. (2015). Professional ethics in extreme circumstances: responsibilities of attending physicians and healthcare providers in hunger strikes. *Theoretical Medicine and Bioethics*, 36(4), 249–263. Available at: <https://doi.org/10.1007/s11017-015-9333-9>

95 Irmak, N. (2015). Professional ethics in extreme circumstances: responsibilities of attending physicians and healthcare providers in hunger strikes. *Theoretical Medicine and Bioethics*, 36(4), 249–263. Available at: <https://doi.org/10.1007/s11017-015-9333-9>

96 WMA (1991, rev. 2017). *WMA Declaration on Hunger Strikes ('Malta Declaration')*. World Medical Association. Available at: <https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/>
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97 Irmak, N. (2015). Professional ethics in extreme circumstances: responsibilities of attending physicians and healthcare providers in hunger strikes. *Theoretical Medicine and Bioethics*, 36(4), 249–263. Available at: <https://doi.org/10.1007/s11017-015-9333-9>

98 WMA (1991, rev. 2017). *WMA Declaration on Hunger Strikes ('Malta Declaration')*. World Medical Association. Available at: <https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/>

Relevance to preventive monitoring

The failure of prison authorities to handle hunger strikes in line with international standards may amount to ill-treatment or torture. Force-feeding is not acceptable under any circumstance, but artificial feeding of a hunger-striker, who is threatened to his/her life and due to coma or a similar mental health condition is incompetent of decision making, may be justified until a condition of competent decision making has been achieved. The Malta declaration on hunger strikers (see under international standards) states in paragraph 23 that *'All kinds of interventions for enteral or parenteral feeding against the will of the mentally competent hunger striker are "to be considered as "forced feeding". Forced feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting'*.

The European Court of Human Rights has received many cases relating to force-feeding prisoners on hunger strike and some of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following case is an example of a case judged by the Court as a violation of article 3:

Ciorap v. Republic of Moldova 19 June 2007. In this case the applicant complained in particular about his conditions of detention, force-feeding after he had decided to go on a hunger strike, and the national courts' refusal to examine his complaint about the force-feeding because he had not paid the court fees.

*The Court held that there had been a violation of Article 3 (prohibition of torture and ill-treatment) of the European Convention regarding the applicant's force-feeding. There was in particular no medical evidence that the applicant's life or health had been in serious danger and there were sufficient grounds to suggest that his force-feeding had in fact been aimed at discouraging him from continuing his protest. Furthermore, basic procedural safeguards prescribed by domestic law, such as clarifying the reasons for starting and ending force-feeding and noting the composition and quantity of food administered, had not been respected. Lastly, the Court was struck by the manner of the force-feeding, including the unchallenged, mandatory handcuffing of the applicant regardless of any resistance and the severe pain caused by metal instruments to force him to open his mouth and pull out his tongue. Less intrusive alternatives, such as an intravenous drip, had not even been considered, despite the applicant's express request. The Court therefore found that the manner in which the applicant had been repeatedly force-fed had unnecessarily exposed him to great physical pain and humiliation, and, accordingly, could only be considered as torture.*⁹⁹

Another clear example, where prisoners were force-fed amounting to torture concerns the force-feeding practices in Guantanamo Bay. The UN Human Rights Commission has stated that it regards the force-feeding at Guantanamo Bay as a form of torture, not only because of the force-feeding in itself, but also because of the way in which it was done. *'By strapping detainees into restraint chairs, pushing a tube up their nose and down their throat, and pumping liquids into their stomach, inmates have described the method as immensely painful'*.¹⁰⁰

Some prisoners in Guantanamo Bay were also exposed to rectal feeding¹⁰¹, which is never ethically acceptable.

99 ECHR (2015). *Hunger strikes in detention*. European Court of Human Rights, 2015. Available at: https://www.echr.coe.int/Documents/FS_Hunger_strikes_detention_ENG.pdf

100 See for instance: <https://www.rt.com/usa/red-cross-guantanamo-maurer-770/>

101 See for instance: <https://www.humanrightsfirst.org/senate-report-cia-torture><https://www.humanrightsfirst.org/senate-report-cia-torture/rectal-rehydration/rectal-rehydration>

International standards and guidance

The World Medical Association published two Declarations which are of relevance to hunger strikes and the role of physicians in hunger strikes, i.e. The Declaration of Tokyo containing Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment in 1975¹⁰², and the Declaration of Malta on hunger strikers, published in 1991 and revised in 1992, 2006 and 2017.¹⁰³

The World Medical Association Declaration of Tokyo

Article 6 of the Declaration of Tokyo states that doctors are not allowed to force-feed hunger strikers. They are supposed to understand the prisoner's independent wishes, and it is recommended to have a second opinion as to the capability of the prisoner to understand the implication of his/her decision and be capable of informed consent: *"Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner"*.

The World Medical Association Declaration of Malta

Below follows a brief summary of the Declaration of Malta, including the key points of interest when monitoring hunger strikes in places of detention as well as the way in which the institution handles the strikes:

- Physicians with dual loyalties are bound by the same ethical principles as other physicians – they must remain clinical independent and their primary obligation is to the individual patient.
- Physicians must assess the mental capacity of individuals seeking to engage in a hunger strike. This involves verifying that an individual intending to fast is free of any mental conditions that would undermine the person's ability to make informed health care decisions.
- Physicians must respect autonomy of competent individuals, even where this will predictably lead to harm. The loss of competence does mean that a previous competent refusal of treatment, including artificial feeding should be respected.
- Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike.
- Physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs. Hunger strikers should not forcibly be given treatment they refuse.
- Trust between physicians and hunger strikers often is the key to achieving a resolution that both respects the rights of the hunger strikers and minimizes harm to them.
- Physicians should ensure informed consent and verify that hunger strikers understand the potential health consequences of fasting and forewarn them in plain language of the disadvantages. Physicians should also explain how damage to health can be minimized or delayed by, for example, increasing fluid and thiamine intake. Since the person's decisions regarding a hunger strike can be momentous, ensuring full patient understanding of the medical consequences of fasting is critical.

102 WMA (1975, rev. 2016). *WMA Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment ('Tokyo Declaration')*. World Medical Association. Available at: <http://www.wma.net/en/20activities/10ethics/20tokyo/>

103 WMA (1991, rev. 2017). *WMA Declaration on Hunger Strikes ('Malta Declaration')*. World Medical Association. Available at: <https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/>

- Physicians should ascertain on a daily basis whether individuals wish to continue a hunger strike and what they want to be done when they are no longer able to communicate meaningfully. The clinician should identify whether the individual is willing, in the absence of their demands being met, to continue the fast even until death. These findings must be appropriately recorded.
- If no discussion with the individual is possible and no advance instructions or any other evidence or note in the clinical records of a discussion exist, physicians have to act in what they judge to be in the person's best interests. This means considering the hunger strikers' previously expressed wishes, their personal and cultural values as well as their physical health.
- It is ethical to allow a determined hunger striker to die with dignity rather than submit that person to repeated interventions against his or her will.
- Artificial feeding, when used in the patient's clinical interest, can be ethically appropriate if competent hunger strikers agree to it.
- When a patient is physically able to begin oral feeding, every caution must be taken to ensure implementation of the most up-to-date guidelines of refeeding.

International UN standards provide only general and basic guidance on how to handle hunger strikes. They do not explicitly refer to the issue of force-feeding. However, the amount of pain and suffering, as well as the subjection to a medical procedure without the consent of a prisoner, may argue for force-feeding to be an act of torture or cruel, degrading and inhuman treatment and a violation of international human rights law, such as the International Covenant for Civil and Political Rights¹⁰⁴ and the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.¹⁰⁵ Additionally, force-feeding is a clear violation of article 12 of the International Covenant of Economic, Social and Cultural Rights. The Committee on Economic, Social and Cultural Rights (CESCR) has in its General Comment 14 (8) focusing on article 12 of the Covenant stated that informed consent is a key aspect of the right to health: *"The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."*¹⁰⁶

It is important, however, to acknowledge the international debate regarding force-feeding, even though the WMA Declarations are clear about the fact that doctors are not allowed to force-feed a prisoner on hunger strike. The ECHR has not been clear that force-feeding is always forbidden, and many countries even have a national law making it permitted, for instance Germany, France and Israel.¹⁰⁷

In 2017, a systematic literature review relating to the ethical issues for doctors in managing hunger strikes in places of detention was conducted, including 23 papers from 12 jurisdictions

104 UNOHRC (1966). *International Covenant on Civil and Political Rights*. United Nations Human Rights Office of the High Commissioner, 1966. Available at: <http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>

105 UN (1984). *UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*. Available at: <https://www.ohchr.org/Documents/ProfessionalInterest/cat.pdf>

106 UNCESCR (2000). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. UN Committee on Economic, Social and Cultural Rights, 2000. Available at: <https://www.refworld.org/type,GENERAL,CE-SCR,4538838d0,0.html>

107 See for example the Harvard International Law Journal: <https://harvardilj.org/2016/12/force-feeding-prisoners-on-a-hunger-strike-israel-as-a-case-study-in-international-law/>

worldwide. The authors concluded that the key themes emerging from the papers are consistent with the WMA Declaration of Malta. The care for prisoners on hunger strike and feeding procedures remain however ethically complex issues for health professionals to be involved in. Also, the situation where non-medical staff would be requested to, for instance, force-feed a prisoner is ethically complex. While the procedure may be incompatible with medical ethics, the consequences of the lack of medical expertise in the procedure may have adverse effects on the well-being of the prisoner, increasing suffering. It is essential for doctors working with prisoners on hunger strike to always strive to act in their best interest and respect their autonomy and dignity, where there seems to be consensus that autonomy should be favored over beneficence.¹⁰⁸

If a mentally competent prisoner (to be assessed by the doctor) has clearly and persistently stated that he/she wants to starve and does not want to be artificially fed, then the doctor must respect this. This should not involve any form of psychological or oral pressure to break the hunger strike. The doctor should inform the person about the possible health consequences from the hunger strike. He/she should also inform him/her about possible unexpected events such as diseases and ailments in the course of the strike, including psychosis or hypoglycaemia, and he/she should ask for the person's preliminary position as to treatment hereof. The doctor must keep meticulous record on a daily basis as to the hunger striker's physical and psychological health, including his/her commitment to continue the strike. The doctor shall despite the person's wish to continue the strike offer, when needed, treatment and palliation for any ailment, equal to what would be offered to any other patient and ensure implementation of the treatment if informed consent is obtained. The doctor needs to accept that the hunger striker may die if he/she will continue the strike, i.e. respect the will of a competent person – even when he/she enters a state of blurred discernment/confusion.

There may be several difficulties related to the doctor's duty in relation to hunger strikes, which can be related to:

a. *The intellectual competency of the hunger striker*

It should appear from the general medical record if a prisoner is mentally/intellectually incompetent. If the doctor looking after a hunger striker is in doubt about this, a second evaluation by another independent doctor, preferably a psychiatrist, must be done. The need for a second opinion of an independent doctor is a general recommendation that should be applied in any case of hunger strikes. Likewise, the record keeping must always be thorough.

b. *The hunger striker's decision to strike, taken under pressure from fellow prisoners or others*

The doctor must take the necessary time to inform the hunger striker about the health consequences of a hunger strike (see for a brief overview box 8 below) and ensure that the person has understood the information. This is also a means to verify that the person is really committed to pursue his/her decision in spite of risks, including for instance irreversible neurological symptoms, and the eventual fatal outcome. If it appears that the person is under group pressure, the doctor must discuss this with the person and consider whether the prisoner can be moved to another setting where such pressure does not exist. Nevertheless, the interpretation of a competent person's motive for the hunger strike should not lead to a decision of force-feeding if the commitment for the strike is persistent. Again, a second opinion/evaluation by another independent doctor may help to clarify the person's position and give him/her a possibility to reflect

108 Gulati et al (2017). Hunger strikes in prison: a narrative systematic review of ethical considerations from a physician's perspective. *Irish Journal of Psychological Medicine*, 35(2):1-8 · July 2017. Abstract available at: <https://www.ncbi.nlm.nih.gov/pubmed/30115194>

once more on the consequences of the strike. If the wish to continue the strike is pursued, it must be respected. If appropriate in the respective country, the doctor should seek advice and support from for instance the national medical association. An assessment of the influence of group pressure is very difficult and using it as an argument to force-feed would, in the most radical interpretation, mean that any group hunger strike could be brought to an end by means of force-feeding which is ethically unacceptable.

- c. *The doctor coming into the scene at a very late stage of the strike, where the appropriate information about competency and will was not documented while still possible*

The doctor who finds him/herself in a situation where colleagues have not fulfilled their obligation to document their encounters with the person, who at this point is unable to express his/her will, should collect as much information as possible, from inter alia assisting staff members, about the striker's personality, mental health and the course of the strike. Such cases are always problematic since the rules of documentation have been violated; hence it is recommended to consult with for instance the national medical association, if appropriate in the respective country. A doctor is the only one who should make decisions on whether force-feeding should be done or not. Prison management and staff should never be the ones being able to take such decisions or intervene in such decisions, nor shall fellow prisoners or the prisoner's family.

BOX 8:

THE HEALTH CONSEQUENCES OF BEING ON HUNGER STRIKE

Being on hunger strike has several physical and psychological health consequences, sometimes irreversible or fatal.

*'The human brain derives energy from storage fat, permitting survival in normal-weight persons for up to 2 to 2,5 months and in obese persons for many months to even 1 year. Serious medical problems begin at a weight loss of approximately 18% of initial body weight in individuals who continue fasting. Starvation is life threatening when more than 30% of the original body weight is lost.'*¹⁰⁹

'When there is a deficit in energy intake, the body consumes its own stocks to maintain blood glucose, its main fuel. The body will first use fat stocks. Then, the body will begin to use muscle and organ tissue to produce energy. Salt and vitamin deficiencies are also harmful for the body. During a hunger strike, in addition to weight loss, many other symptoms are common:

- *Sensation of hunger at the beginning then loss of appetite*
- *Apathy and irritability*
- *Headache, dizziness, difficulty getting up and moving, stroke*
- *Anxiety, sadness, insomnia, impaired concentration*
- *Abdominal pain, peptic ulcers, nausea, constipation (sometimes diarrhoea)*
- *Very painful nephrolithiasis, renal failure*
- *Reduction of blood pressure and respiratory rates*

(continues)

¹⁰⁹ Cahill (1970). Starvation in man. *N Engl J Med.* 1970;282(12):668-675. Available at: <http://garfield.library.upenn.edu/classics1991/A1991FT75900001.pdf>

- Neurological disorders: limb paralysis, blindness, coma
- Death on neurological, cardiac, pulmonary or renal problems, etc.
- Implicating no food and water intake
- Drowsiness, neurological disorders
- Cardiac or lung disorders
- Death¹¹⁰

*'The fasting hunger striker progresses through phases of symptoms. Sometimes after a short period of euphoria and well-being, the hunger striker will begin to experience symptoms of weakness and dizziness, which can be disabling [...]. Abdominal pain is common. Because both hunger and thirst mechanisms are lost, volume depletion occurs.'*¹¹¹

*'Emotional lability is a late feature of fasting and can complicate psychological evaluation. Vomiting and difficulty swallowing water occur during this most unpleasant phase of fasting. From 40 days onward, progressive asthenia, confusion, and somnolence occur. Loss of hearing, blindness, hemorrhage, and death from cardiovascular collapse and dysrhythmias eventually occur.'*¹¹²

Finally, a note has to be made regarding re-feeding of prisoners who have been on hunger strike. People who have been on hunger strike may likely suffer from malnutrition with major depletion of vitamins and electrolytes. This imposes serious risks for getting re-feeding syndrome, a potentially fatal condition with metabolic disturbances leading to cardiac, pulmonary and neurological symptoms, and this is why re-feeding must be very carefully administered following a hunger strike.¹¹³ In 2006, guidelines on re-feeding syndrome were published by the National Institute for Health and Clinical Excellence (NICE) in England and Wales. To ensure adequate prevention, the NICE guidelines recommend a thorough nutritional assessment before refeeding is started. They recommend refeeding to be started at no more than 50% of energy requirements in "patients who have eaten little or nothing for more than 5 days". The rate can then be increased if no refeeding problems are detected on clinical and biochemical monitoring.¹¹⁴

Monitoring methodology

The monitor should before the visit know the national legislation and the prison system's regulations about hunger strikes and should request existing guidelines for the institution's staff. The assessment of the prison (health) service's approach to hunger strikes should be based on those, on the information obtained during interviews, and on the practical approach of the clinic as documented in the medical records of hunger strikers.

If a hunger strike in a place of detention is done out of moral, political or philosophical considerations, it is usually outside of the scope of the prison. In that case it is rarely relevant to health monitors to enter into the background of the conflict. If the hunger strike however stems from problems within the prison, monitors may choose to look into the underlying problems in line

110 Getaz et al. (2012). Hunger strike among detainees: guidance for good medical practice. *Swiss Med Wkly.* 2012;142:w13675. Available at: <https://smw.ch/article/doi/smw.2012.13675>

111 Kerndt et al (1982). Fasting: the history, pathophysiology and complications. *West J Med.* 1982;137(5):379- 399. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1274154/pdf/westjmed00207-0055.pdf>

112 Crosby et al (2007). Hunger Strikes, Force-feeding, and Physicians' Responsibilities. *The Journal of the American Medical Association.* September 2007. Available for download at: https://www.researchgate.net/publication/6171973_Hunger_Strikes_Force-feeding_and_Physicians_Responsibilities

113 WHO/Europe (2014). *Prisons and Health.* Copenhagen, Denmark. Available at: www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

114 NICE (2006). *Guidelines - Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition.* National Institute for Health and Care Excellence, UK, 2006. Available at: <https://www.nice.org.uk/guidance/cg32>

with the way they tackle any other issue monitored. Monitors should maintain neutrality and objectivity considering that the conflict often is heavily politicized.

Interviews with prisoners could for instance focus on the background of any recent hunger strike that has taken place in the institution. Prisoner could also be asked about the consequences of the hunger strike and their experience with how the strike was dealt with by the institution. If there are prisoners on hunger strike at the time of the monitoring visit or prisoners who have been on hunger strike previously, the monitor should aim to talk to these prisoners if possible.

Prison health staff could be asked about their role in the management of a hunger strike and whether there are any past incidents of prisoners having been force-fed or artificially fed and how they assess the correctness and appropriateness of the way in which things were managed.

Interviews with prison guards should foremost concentrate on a description of any hunger strike that may have taken place in the institution, its background and consequences. They could also be asked about their role, if any, in the management of the hunger strike.

The interview with the prison management should, along the same lines, concentrate on getting a full picture of a hunger strike that may have taken place in the institution. Prison management could further elaborate on their role in the management of the hunger strike and on whether anything changed in the institution as an effect of the hunger strike.

Observations are mostly relevant when there are prisoners on hunger strike while the monitoring visit takes place. The observations could then give insight into the conditions in which the prisoners on hunger strike are kept and whether they are treated with respect and dignity.

A review of documentation should foremost focus on a review of medical records of prisoners who are or have been on a hunger strike and on whether there are any instructions available to (health) staff on how to manage a hunger strike.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

ECHR (2015). Hunger strikes in detention. European Court of Human Rights. Available at: https://www.echr.coe.int/Documents/FS_Hunger_strikes_detention_ENG.pdf

NICE (2006). *Guidelines - Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition*. National Institute for Health and Care Excellence, UK, 2006. Available at: <https://www.nice.org.uk/guidance/cg32>

WHO/Europe (2014). *Prisons and Health*. Copenhagen, Denmark. Available at: www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

WMA (1991, rev. 2017). *WMA Declaration on Hunger Strikes ('Malta Declaration')*. World Medical Association. Available at: <https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/>

WMA (1975). *WMA Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment ('Tokyo Declaration')*. World Medical Association. Available at: <http://www.wma.net/en/20activities/10ethics/20tokyo/>

3.14. Health promotion and disease prevention

Health promotion is defined by the World Health Organization as *'the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions'*.¹¹⁵

Disease prevention differs from health promotion in that it focusses specifically on efforts aimed at reducing the development and severity of disease. WHO defines it as *'specific, population-based and individual-based interventions for primary and secondary (early detection) prevention, aiming to minimize the burden of diseases and associated risk factors..... Primary prevention refers to actions aimed at avoiding the manifestation of a disease..... Secondary prevention deals with early detection when this improves the chances for positive health outcomes...'*¹¹⁶

Relevance to preventive monitoring

Lack of health promotion and disease prevention initiatives in places of detention may in some cases amount to ill-treatment, for instance when a prisoner gets infected with a communicable disease like HIV or hepatitis due to the absence of harm reduction measures or a lung disease develops or progresses due to second-hand smoking.

The European Court of Human Rights has received many cases which indirectly relate to a lack of health promotion and disease prevention in the place of detention. Some of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*), for example the following:

Eleftheriadis v. Romania 25 January 2011. The applicant, who suffers from chronic pulmonary disease, is currently serving a sentence of life imprisonment. Between February and November 2005 he was placed in a cell with two prisoners who smoked. In the waiting rooms of the courts where he was summoned to appear on several occasions between 2005 and 2007, he was also held together with prisoners who smoked. The applicant further claimed to have been subjected to second-hand tobacco smoke when being transported between the prison and the courts.

The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention, observing, in particular, that a State is required to take measures to protect a prisoner from the harmful effects of passive smoking where, as in the applicant's case, medical examinations and the advice of doctors indicated that this was necessary for health reasons. In the instant case, it appeared possible to separate the applicant from prisoners who smoked, given that there was a cell in the prison containing only non-smokers. Furthermore, following the period during which the applicant had been detained in a cell with smokers, the medical certificates issued by several doctors recorded a deterioration in his respiratory condition and the emergence of a further illness, namely chronic obstructive bronchitis. As to the fact that he had been held in court waiting rooms with prisoners who smoked – even assuming that it had been for short periods – this had been against the recommendations of doctors, who had advised the applicant to avoid smoking or exposure to tobacco smoke. The fact that the applicant had eventually been placed in a cell with a non-smoker appeared to have been due to the existence of sufficient capacity in the prison in which he was detained at that particular time rather than to any objective criteria in the domestic legislation ensuring that smokers and non-smokers were detained separately. Thus, there was nothing to indicate that the applicant would continue to be held in such

¹¹⁵ https://www.who.int/topics/health_promotion/en/

¹¹⁶ <http://www.emro.who.int/about-who/public-health-functions/health-promotion-disease-prevention.html>

*favorable conditions if the prison where he was currently detained were to be overcrowded in the future.*¹¹⁷

International standards and guidance

Prisoners' right to health is equivalent to the right to health of people living in the general community and this right includes the right to health promotion and disease prevention. This is outlined in international law, such as in article 11 of the European Social Charter:

'Article 11 – The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

- 1. to remove as far as possible the causes of ill-health;*
- 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;*
- 3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.*¹¹⁸

Several rules, declarations, resolutions and policy documents by international organizations and bodies, including the World Health Organization and the Council of Europe, underline the obligation of prison authorities to provide preventive health care in places of detention, especially against HIV and hepatitis C epidemics.¹¹⁹

As mentioned several times throughout this manual, the burden of diseases is greater in prison populations than in age-matched groups in the outside community. Moreover, the prison environment is in general unhealthier than the environment outside, inter alia, because prisoners live in close contact to each other, prisoners continue illicit drug use and often by unsafe injecting practices, and possibilities for physical activity are restricted. Hence the need for health promotion and disease prevention is increased.

Health promotion describes the *'process of enabling people to increase control over, and to improve, their health'*. It includes health information and education which is vital to promoting health, including in places of detention. Health promotion seeks to bring about changes in individuals, groups, institutions, and policies in order to improve population health. The Ottawa Charter for Health Promotion, adopted by the WHO in 1986, identifies five critical activities for health promotion:

1. Developing personal skills for health
2. Creating supportive environments
3. Strengthening community action for health
4. Reorienting health services, and

117 ECHR (2019). *Prisoners' health-related rights*. European Court of Human Rights, 2019. Available at : https://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

118 CoE (1996). *European Social Charter (revised)*. Council of Europe, Strasbourg, 1996. Available at: <https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf93>

119 CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.refworld.org/pdfid/4d7882092.pdf>
WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, Denmark. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf?ua=1

5. Building healthy public policy¹²⁰

The World Health Organization states that increased efforts are required to ensure a health promoting prison, which it describes as having the following elements:

- Health services equivalent to what is provided in the country as a whole
- The risks to health reduced to a minimum
- The dignity and human rights of every prisoner respected¹²¹

In its publication on Prisons and Health, the WHO Regional Office for Europe advocates for health promotion and disease prevention in places of detention as a 'whole-prison' or 'settings' approach. This approach draws on three key elements:

1. Implementation of policies that specifically promote the health of prisoners and staff (such as smoking policy or promoting exercise);
2. An environment and regime in the place of detention that is supportive of health; and
3. Health education, disease prevention and other health promotion initiatives that address the health needs assessed within the place of detention.¹²²

This makes clear that health promotion and disease prevention are not solely a responsibility of the prison health service but instead of the whole prison service, including policy makers, prison management, prison staff and prison health staff. With knowledge of the risk factors and pathologies in the prison population, specific actions can be defined for the promotion of health and prevention of (spread of) disease within places of detention. In this regard, communicable diseases such as HIV/AIDS, Hepatitis B/C and TB are clear examples, because of their relatively high prevalence in places of detention and the relative high risk for these diseases to spread to others within the institution in the absence of effective health promotion and disease prevention strategies, such as availability of opioid substitution therapy and needle and syringe exchange programmes (see also the chapter on substance use disorders in Section 5).¹²³

Health promotion and disease prevention initiatives cannot be entirely similar to those available in the general community but need to be adapted to the prison population and the specific high-risk behaviours prevalent in places of detention, including foremost exchanges of equipment, unsafe drug injecting, tattooing and unsafe sexual relationships. Actions to reduce unsafe sexual relationships include foremost the distribution of condoms free of charge. Good experiences with condom distribution programmes have been reported worldwide. For instance, in the US, a study evaluating the impact of installing a condom-dispensing machine in a jail in California showed that sexual activity did not increase, custody operations were not impeded, and staff acceptance of condom access for prisoners increased.¹²⁴ A study by Dolan et al in 2004 in Australia demonstrated that making condoms available leads to decreased risk behaviors, suggest-

120 WHO (1986). *Ottawa Charter for Health Promotion*. World Health Organization, Geneva. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf?ua=1

121 <http://www.who.int/topics/prisons/en/>

122 WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, Denmark. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf?ua=1

123 UNODC/WHO/UNAIDS (2008). *HIV and AIDS in places of detention. A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings*. United Nations Office on Drugs and Crime, World Health Organizations and Joint United Nations Programme on HIV/AIDS, 2008. Available at: http://www.who.int/hiv/pub/idu/detention_toolkit.pdf?ua=1

124 Sylla, Harawa and Reznick (2010). The First Condom Machine in a US Jail: The Challenge of Harm Reduction in a Law and Order Environment. *Am J Public Health*, 2010 June; 100(6): 982–985. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2866591/>

ing that condom accessibility may indeed help to reduce transmission of HIV and other sexually transmitted diseases (STDs) in prisons.¹²⁵ Another study in Australia in 2015 also showed that condoms were predicted to effectively reduce the incidence of STDs in prison.¹²⁶

Health promotion and disease prevention in places of detention should be seen as both a set of activities within the five categories identified by the World Health Organization to improve health in places of detention, and as a mindset that sees health in places of detention as an integral part of public health, contributing to improving health in the overall population.

Although the prison service as a whole has a responsibility for health promotion and disease prevention, there is always a special role for prison health professionals who have the duty to protect prisoners' physical and mental health, including the prevention and treatment of disease and the promotion of healthy choices, behavior and detention conditions (cf. Mandela Rule 35). In some countries, standards for health promotion and disease prevention are part of national standards for health services in places of detention.

Several countries have conducted actions to promote health among prisoners. For instance, Djachenko et al. published a literature review in 2015 on smoking cessation in male prisoners in Australia. Based on 12 studies included in the review, the authors state that a strong "pro-smoking" culture in prisons is common and that many prisoners continue to smoke irrespective of an enforced ban. They however also state that smoking cessation strategies can be successful if implemented systematically and supported by consistent policies.¹²⁷

A review by Santora et al. on Norwegian health promotion policies in prison settings in 2014, showed the effective involvement of Norwegian authorities in health promotion through health promoting actions applied in prison settings. The actions are anchored in health policy's overarching goals of equity and "health in all public policy", aiming to reduce social inequalities in population health.¹²⁸ The fact that in Norway the responsibility for health in prisons lies with the Ministry of Health is surely beneficial to ensure the inclusion of prison settings in general health promotion initiatives.

A special focus needs to be put on the health risks to which prisoners may be specifically exposed to in a prison setting, and how they are handled. This includes for instance suicide risk, the risk of violence, threats to mental health during solitary confinement, torture and ill-treatment, and communicable diseases. Protection against acquiring serious transmittable diseases is a right of prisoners, and the effectiveness of screening and intervention procedures offered by the prison health service are highly important. National public health programmes such as the prevention, treatment and care of HIV/AIDS, TB and mental health should be applied in prison settings, and programmes should be in place to address drug dependency, including harm reduction programmes and opioid substitution therapy.

Health professionals working in places of detention need to include a strong focus on the impact of environmental factors in the place of detention on the prisoners' health (cf. Mandela Rule 35). It is their responsibility to advise prison management about the negative effects on

125 Dolan, Lowe, Shearer (2004). Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine & Ethics*, 32: 124-128.

126 Scott et al (2015). Modelling the Impact of Condom Distribution on the Incidence and Prevalence of Sexually Transmitted Infections in an Adult Male Prison System. *PLoS One*. 2015; 10(12). Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4691199/>

127 Djachenko et al. (2015). Smoking cessation in male prisoners: a literature review. *International Journal of Prison Health*. 2015;11(1):39-48. Abstract available at: <https://www.ncbi.nlm.nih.gov/pubmed/25751706>

128 Santora et al. (2014). Health promotion and prison settings. *International Journal of Prison Health*. 2014;10(1):27-37. Available at: https://www.researchgate.net/publication/260930972_Health_promotion_and_prison_settings

health of certain environmental factors, such as poor ventilation and poor sanitation (see also Section 4 on prison health factors). They have an important role in advising management about necessary health promotion and disease prevention measures to initiate and to guarantee a safe and as healthy as possible living environment for the prisoners. They also have a key role in any health education to prisoners, such as on hygiene and smoking cessation.

Challenges are often related to conditions in places of detention such as overcrowding, smoking and unsafe drug use and to prisoners having poor health-related habits and very low health education. It is important that all those working in a place of detention, including prison management, prison health staff and prison guards, acknowledge the importance of health promotion and disease prevention for the benefit of the prisoners but also in the interest of overall public health.

Monitoring methodology

Monitors should be informed about national health promotion and disease prevention campaigns in order to see whether these are also implemented in the place of detention.

During the monitoring visit, the health monitor should use all sources of information available to him/her, including interviews with prisoners, prison health staff, prison guards and prison management, observations and documentation, in order to properly assess the way in which the institution handles health promotion and disease prevention.

Interviews with prisoners will give insight into their awareness of and exposure to health promotion and disease prevention initiatives. They could for instance be asked whether they received any information on how to prevent getting sick/improving your health when they entered the institution, for instance focused on the availability of condoms, availability of clean needles and syringes, and anti-smoking initiatives.

Interviews with prison health staff will give insight into the most challenging public health threats in the institution and how the institution deals with these in terms of disease prevention and health promotion. The prison health staff could also be asked whether the institution has a strategy on health promotion and disease prevention in place and whether they provide any health education to prisoners.

Prison guards will be able to inform the monitor about any health promotion initiatives that may have been held in the institution. They will also be able to inform the monitor about any harm reduction measures in place, such as free availability of condoms or clean needles and syringes and how these measures function in practice.

The health monitor should ask the prison management about general policies and strategies in the institution with regard to health promotion and disease prevention and the main challenges faced.

During the entire monitoring visit, the health monitor should use his/her observational skills to see whether there are any posters, leaflets, brochures etc. available to the prisoners, with the aim to promote their health and prevent disease.

Documents that could be consulted include foremost registers, to see whether these are available for the most challenging public health threats. The monitor could also look whether written instructions are available to prison health staff and/or prison guards addressing health promotion and disease prevention.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

Niveau (2006). Prevention of infectious disease transmission in correctional settings: a review. *Public Health* 2006 Jan;120(1):33-41. Available at: <http://www.sciencedirect.com/science/article/pii/S003335060500154X>

Santora et al. (2014). Health promotion and prison settings. *International Journal of Prison Health*. 2014;10(1):27-37. Available at:

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, Denmark. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf?ua=1

3.15. Palliative care

Palliative care is a multidisciplinary approach to specialized medical care for people in the last stages of a life-limiting illness. The main goal of palliative care is to improve a person's quality of life. Palliative care consists of offering administration of appropriate medication as well as nursing and care ensuring the patient's dignity.

The World Health Organization defines palliative care as *'an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'*.¹²⁹

Palliative care is often insufficient or even non-existent in places of detention and therefore prisoners at the later stages of a life-limiting illness are often transferred to a hospital or a specialized unit. Preferably however, the person should be released on compassionate grounds in order to be with family and friends, and be provided with palliative care in the community, given that the family is willing to and has the resources to care for the person and that the community health care is within reach and operational.

Relevance to preventive monitoring

Not providing a person, who suffers from the last stages of a life-limiting illness, with palliative care, may amount to ill-treatment. Palliative care is aimed at providing relief from physical and mental symptoms and stress. When for instance physical pain is very severe for a prisoner suffering from cancer and he/she does not receive palliative care including pain management, this is a clear example of ill-treatment. Also, not providing a severely ill person with the needed assistance to personal hygiene, will amount to ill-treatment.

In several cases relating to a lack of care for severely ill prisoners, the European Court of Human Rights has found violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following is an example of a case judged by the Court as a violation of article 3 (as well as two other articles of the Convention):

Gülşay Çetin v. Turkey 5 March 2013. The case concerned a person who complained that she had been kept in prison, initially pending trial and later following her conviction for murder, despite suffering from advanced cancer. She alleged in particular that the authorities had refused to release her pending trial, to suspend her detention or to grant a presidential pardon and alleged that this had exacerbated her physical and mental suffering. She died of her illness in a hospital's prison ward and her father, mother, sister and brother pursued the proceedings she had instituted before the Court.

The Court observed that in accordance with Article 3 (prohibition of inhuman or degrading treatment) of the Convention, the health of prisoners sometimes called for humanitarian measures, particularly where an issue arose as to the continued detention of a person whose condition was incompatible in the long term with a prison environment. In the present case, it concluded that the conditions of the applicant's detention, both before and after her final conviction, had amounted to inhuman and degrading treatment, contrary to Article 3, and that she had been discriminated against in that, while in pre-trial detention, she had not been eligible for the protective measures applicable to convicted prisoners suffering from serious illnesses, in violation of Article 3 taken in conjunction with Article 14 (prohibition of discrimination) of the Convention. Lastly, the Court recommended under Article 46 (binding force and execution of judgments) that the Turkish authorities take measures to protect the

129 See the WHO website on palliative care: <http://www.who.int/cancer/palliative/definition/en/>

health of prisoners with incurable diseases, whether they were being held pending trial or following a final conviction.¹³⁰

International standards and guidance

There have been published many guidelines on palliative care, both by international bodies such as the World Health Organization and the European Association for Palliative Care, as well as by national bodies.

In 2004, the World Health Organization Regional Office for Europe issued its publication *'The solid facts. Palliative care'*. In this publication, WHO stresses that *'some vulnerable groups within society have unmet needs and equal access to good quality palliative care must be ensured'*. The vulnerable groups mentioned in the publication include prisoners.¹³¹ In the same year, the World Health Organization published its Global Atlas of Palliative Care at the End of Life.¹³²

In 2010, the European Association for Palliative Care (EAPC) issued a White Paper on standards and norms for hospice and palliative care in Europe.¹³³ The EAPC supports the recommendations given by the WHO in 2004, which are the following:

- Recognize the public health implications of aging populations
- Undertake a quality audit of palliative care services
- Invest in the development of core data sets
- Invest in audit and quality improvement methods/ reward the involvement of health organizations
- Ensure that multidisciplinary services are adequately funded, rewarded and supported
- Ensure that the training of healthcare professionals includes sufficient time devoted to palliative medicine and that professionals are supported to keep up to date
- Act against stereotypes that mean older people are not offered palliative care when they need it.

Although the above standards and guidelines do not include a specific focus on palliative care in places of detention, they apply to these settings as much as to community settings (cf. the principle of equivalence of care).

The European Committee for the Prevention of Torture (CPT) outlines in its CPT standards, standard 70, that:

'... typical examples of this kind of prisoner are those who are the subject of a short-term fatal prognosis, who are suffering from a serious disease which cannot be properly treated in prison conditions, who are severely handicapped or of advanced age. The continued detention of such persons in a prison environment can create an intolerable situation. In cases of this type, it lies with the prison doctor to draw up a report for the responsible authority, with a view to suitable alternative arrangements being made.'

The UN Mandela Rules do not make specific reference to palliative care.

130 European Court of Human Rights (2019). *Factsheet – Prisoners' health-related rights*. February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

131 WHO/Europe (2004). *The solid facts. Palliative care*. World Health Organization Regional Office for Europe, Copenhagen, 2004. Available at: http://www.euro.who.int/__data/assets/pdf_file/0003/98418/E82931.pdf

132 WHO (2014). *Global atlas of palliative care at the end of life*. World Health Organization, Geneva, 2014. Available at: http://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf

133 EAPC (2010). White Paper on standards and norms for hospice and palliative care in Europe: part 1. *Recommendations from the European Association for Palliative Care*. European Journal of Palliative Care, 2010; 17(1). Available at: <http://www.eapc-net.eu/LinkClick.aspx?fileticket=f63pXXzVNEY=&tabid=735>

Good quality care towards the end of life must be recognized as a basic human right. Terminally ill prisoners, if they have support from family or friends in the community, should in principle be released on compassionate grounds so that they can die with dignity at home in the company of family or friends, or alternatively in a nursing home, hospital or hospice. In many countries, however, compassionate release because of life-limiting illness does not take place, either because there is not such provision or because it is not used appropriately. The monitoring team should always recommend such provision and its appropriate implementation.

According to a study in 2014, little is known about the extent to which palliative care is available within prison health care systems globally.¹³⁴ Most available research stems from the US and the UK. From these studies, the authors identified common elements of promising practices, including the use of prisoner volunteers, multi-disciplinary teams, staff training, and partnerships with community hospices. The obstacles identified for implementing palliative care in prison included ethical dilemmas based on custody versus care, lack of trust between staff and prisoners, safety concerns, concerns over prisoners' potential misuse of pain medication, and institutional, staff, and public apathy toward terminally ill prisoners and their human rights to health in the form of compassionate and palliative care, including the use of compassionate release laws. The authors conclude that more research is needed to document human rights violations as well as evidence-based practices in palliative and end-of-life care in prisons.¹³⁵

In the US and the UK, palliative care is increasingly being made available within places of detention. In the US, approximately 70 prisons have hospice units linked closely to community-based hospice programmes. These hospice units have been shown to produce cost-effective, high-quality end-of-life care, but there remain several challenges, including regarding the appropriate use of volunteers in prison hospice units, the trust between the patients and the prison health staff, the use of narcotics for pain release, and the support mechanisms available to prisoners making decisions about life-prolonging treatment. In the UK, palliative care in prison provided by community providers is the commonly used care model for seriously ill prisoners.¹³⁶ While these models are preferred to a situation where no palliative care is offered at all, the most favored option would always be to release the patient on compassionate grounds.

Monitoring methodology

During the visit, the monitor should use all information sources available to him/her, including interviews with prisoners, prison management, prison health staff and prison guards, observations and documentation, in order to assess the way in which the institution deals with terminally-ill prisoners and provision of palliative care.

The monitor should ask the prison management about the general procedures and practices in the institution with regard to terminally ill prisoners. Questions that could be asked include for instance whether terminally ill prisoners are allowed to receive more visits from family members and friends than other prisoners, and whether prisoners with a terminal illness in the last period of their life could be released on compassionate grounds.

When interviewing prisoners, the monitor should aim to include an interview with at least one terminally ill prisoner, if possible and morally justified. Questions could for instance concentrate

134 Mashi, Marmo and Han (2014). Palliative and end-of-life care in prisons: a content analysis of the literature. *International Journal of Prison Health*, 2014;10(3):172-97. Summary available at: <https://www.ncbi.nlm.nih.gov/pubmed/25764177>

135 Mashi, Marmo and Han (2014). Palliative and end-of-life care in prisons: a content analysis of the literature. *International Journal of Prison Health*, 2014;10(3):172-97. Summary available at: <https://www.ncbi.nlm.nih.gov/pubmed/25764177>

136 Stone, Papadopoulos and Kelly (2011). Establishing hospice care for prison populations: an integrative review assessing the UK and USA perspective. *Palliative Medicine*, 2011, 26(8):969–978. Available at: <http://journals.sagepub.com/doi/pdf/10.1177/0269216311424219>

on the care and treatment they receive by the prison health service and on the help and support they get from prison guards (and prisoners). They could also be asked about their possibilities for contact with relatives.

Interviews with prison health staff will give the monitor further information on the care and treatment available to terminally ill patients. They could for instance be asked which treatment and care is available and whether there are challenges when it comes to providing palliative care in the institution. They could also be asked whether there is access to specialized palliative consultants, if needed.

Prison guards could for instance elaborate on their role when it comes to providing help and support to terminally ill prisoners and on how these prisoners have access to a health professional on short notice whenever needed. They could also be asked whether other prisoners have a supporting role, for instance as assistants.

Observations should focus on the accommodation of terminally ill prisoners, for instance looking whether the standard of hygiene and bedding and the temperature and lightning are adequate. The monitor could also check whether there is a 'call system' in reach of the patient, to call for urgent help if needed.

Documents should be consulted, for instance looking into existing guidelines and the medical records of terminally-ill prisoners to see what is documented with regard to palliative care.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.refworld.org/pdfid/4d7882092.pdf>

EAPC (2010). White Paper on standards and norms for hospice and palliative care in Europe: part 1. *Recommendations from the European Association for Palliative Care*. European Journal of Palliative Care, 2010; 17(1). Available at: <http://www.eapcnet.eu/LinkClick.aspx?fileticket=f-63pXXzVNEY=&tabid=735>

WHO (2014). *Global atlas of palliative care at the end of life*. World Health Organization, Geneva, 2014. Available at: http://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf

WHO/Europe (2004). *The solid facts. Palliative care*. World Health Organization Regional Office for Europe, Copenhagen, 2004. Available at: http://www.euro.who.int/__data/assets/pdf_file/0003/98418/E82931.pdf

SECTION 4: MONITORING PRISON HEALTH FACTORS

4.1. Introduction

Prison health factors are factors in a place of detention that directly or indirectly impact on the health of the people staying in that place. They include a wide range of issues, ranging from detention conditions such as the accommodation and hygiene, to treatments such as the daily regime and activities and the use of disciplinary measures.

Prison conditions vary widely across places of detention worldwide. Especially developing countries often face huge problems due to overcrowding and poor prison conditions which are frequently related to a severe lack of resources. Food may be scarce and hygiene and sanitary conditions are often extremely poor contributing to spread of diseases and overall poor health of prisoners.

In many (in particularly low income) countries, prison overcrowding and scarcity of foods and goods is a constant and serious problem making life in prison very difficult. This forms the basis for a black market where accommodation and all goods have a price and some prisoners are far better off than others. It is important that monitors are aware of such mechanisms, which may result in gross violations of the prisoners' rights as well as violence.

Treatments of prisoners also vary widely and are sometimes influenced by the prison conditions. For example, if a place of detention is severely overcrowded, it may become more difficult to offer prisoners a range of daily activities and work because there may simply not be enough space and/or resources available. However, prison conditions should never be used as an excuse for poor treatment because no matter how poor the conditions, prison authorities are responsible to provide treatment options that are respectful and in accordance with international standards and for a culture in the institution reflecting these.

As outlined in several international standards, all prisoners are entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity, which implies conditions and treatment as much as possible conducive to their health. If a State is to comply with its obligation to respect the prisoner's human dignity and fulfil its duty of care, certain basic requirements need to be met, including minimum standards on accommodation, hygienic conditions, clothing and bedding, nutrition and exercise.

International standards and guidance

Many of the headlines of the Mandela Rules relate directly or indirectly to health. Of great relevance to prison health factors, the Mandela Rules stress in Rule 42 that: *'all the general living conditions addressed in these rules, including those related to light, ventilation, temperature, sanitation, nutrition, drinking water, access to open air and physical exercise, personal hygiene, health care and adequate personal space, shall apply to all prisoners without exception'*.

The elements outlined in the Mandela Rules, which are most directly relevant to health are the following:

- Accommodation (Rule 13)
- Cleanliness (Rule 18)
- Clothing (Rule 19)
- Food (Rule 20)
- Exercise (Rule 23)
- Restrictions and disciplinary sanctions (Rule 43)

In 2005 (updated in 2013), the International Committee of the Red Cross published its handbook on water, sanitation, hygiene and habitat in prisons, which offers a comprehensive summary of the practical experience gained during their monitoring visits. The handbook is a good reference for assessing the appropriateness of a range of conditions in places of detention.¹³⁷ Moreover, in 2017 ICRC published a practical guide on health care in detention, including a range of prison health factors, how to assess them, and what minimum requirements they have.¹³⁸ The guide provides a good reference for monitors and reference to the guide is made in several of the following chapters.

Monitoring methodology

When assessing each of the prison health factors, the monitor may want to consider the following aspects:

- Is this topic *regulated* by any law, guideline or procedure or is its implementation up to the discretion of the individual staff member?
- Does any mechanism of *transparency* exist, i.e., must the staff member prepare a written report for his/her supervisor or enter data into the prisoner's file that a certain event happened?
- Is there any *accountability* if the staff member overstepped the regulatory guidelines?

The way to monitor prison health factors is mainly by inspection of facilities and by interviewing informants. The findings may be seen together with some of the health and health system patterns described in Sections 3 and 5 of this manual. For instance, lack of cleanliness may be classified as degrading treatment, and may also be linked with for instance infestations and epidemics.

The prison health staff has a special responsibility in monitoring prison health factors, and to report to the prison director in case conditions are not satisfactory. This is stated in Mandela Rule 35: "*The physician or competent public health body shall regularly inspect and advise the director on... food... hygiene... sanitation, temperature, lighting and ventilation... clothing and bedding... physical education and sports*" and is elaborated on in Section 3 in the chapter on the role of the prison health professional and dual obligation dilemmas. The health monitor should assess whether this is done routinely. For instance, do health professionals routinely go around in the institution to check the hygiene, sanitation, nutrition etc.? And what actions do/can they take if problems are noted?

¹³⁷ ICRC (2013). *Water, sanitation, hygiene and habitat in prisons*. By Pier Giorgio Nembrini. International Committee of the Red Cross, Geneva, 2013. Available at: https://www.icrc.org/eng/assets/files/other/icrc_002_0823.pdf

¹³⁸ ICRC (2017). *Health care in detention. A practical guide*. International Committee of the Red Cross, Geneva, 2017. Available at: https://shop.icrc.org/health-care-in-detention-a-practical-guide.html?__store=default&_ga=2.254986890.36091486.1571136686-1731022843.1567763882

Monitoring prison health factors will ultimately lead to insight into a number of issues, i.e.:

- If and how the prison health factors constitute a health risk to prisoners/ a risk that prisoners are hindered from enjoying the highest attainable standard of health.
- If and how the prison health factors contribute to the prevention of torture and ill-treatment or in fact may increase the likelihood of their occurrence in the place of detention.

The health monitoring matrix is a useful tool when monitoring prison health factors and includes all factors as will be discussed in the remaining of this chapter (figure 5).

FIGURE 5.
HEALTH MONITORING MATRIX TOOL – PRISON HEALTH FACTORS

Aspects of prison health services	Sources							
	Prisoners	Health staff	Prison guards	Prison management	Observations	Documents		
						Medical records	Registers	Written instructions
Hygiene								
Nutrition								
Accommodation, sanitation and ventilation								
Use of solitary confinement								
Use of body searches								
Use of urine samples								
Use of force								
Use of physical restraint measures								
Safety and security								

Further reading

ICRC (2013). *Water, sanitation, hygiene and habitat in prisons*. By Pier Giorgio Nembrini. International Committee of the Red Cross, Geneva, 2013. Available at: https://www.icrc.org/eng/assets/files/other/icrc_002_0823.pdf

ICRC (2017). *Health care in detention. A practical guide*. International Committee of the Red Cross, Geneva, 2017. Available at: https://shop.icrc.org/health-care-in-detention-a-practical-guide.html?__store=default&_ga=2.254986890.36091486.1571136686-1731022843.1567763882

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

4.2. Hygiene

Hygiene refers to conditions and practices conducive to maintaining health and preventing disease, especially through cleanliness. Poor hygiene in places of detention contributes to health problems and spread of diseases among prisoners as well as prison staff. For instance, prisoners who do not have the opportunity to wash themselves and their clothing regularly, may be prone to catching skin diseases or parasites and pass on their condition to others. Moreover, unhygienic facilities are attractive for insects such as cockroaches, fleas, lice and bedbugs.

It is important that good hygiene is given priority by the institution to prevent disease and contribute to improved overall prison conditions and prisoners' dignity and health, both at individual and collective level. Maintaining good hygiene can be challenging, especially when facilities are old and poorly maintained, and the institution is overcrowded.

Relevance to preventive monitoring

Prisoners have the right to reside in facilities of basic hygienic standards and if prison authorities do not address issues related to poor hygiene, this could surely amount to ill-treatment. Regular access to clean water and sanitary and kitchen facilities which function well, is essential to maintain people's dignity.

In extreme cases, lack of hygiene could even amount to torture, for instance, when prisoners intentionally are prevented to access a toilet for long periods of time, therefore forced to reside in very unhygienic conditions and prone to contracting disease.

The European Court of Human Rights has received many cases related to unhygienic conditions in places of detention. The below example shows how unhygienic conditions can be a violation of article 3 of the Convention of Human Rights ('No one shall be subjected to torture or to inhuman or degrading treatment or punishment'), also in a high-income country:

Vasilescu v. Belgium. 18 March 2014. This case mainly concerned the applicant's condition of detention in Antwerp and Merksplas Prisons. The applicant complained in particular that his physical conditions of detention had been inhuman and degrading.

*The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention regarding the physical conditions of the applicant's detention. It noted in particular that in addition to the problem of prison overcrowding, the applicant's allegations regarding the sanitary conditions, particularly access to running water and the toilets, were most plausible and reflected the realities described by the European Committee for the Prevention of Torture (CPT) in the various reports drawn up following its visits to Belgian prisons. While there was nothing to indicate that there had been a real intention to humiliate or debase the applicant during his detention, the Court found that his physical conditions of detention in Antwerp and Merksplas Prisons had subjected him to hardship exceeding the unavoidable level of suffering inherent in detention and amounted to inhuman and degrading treatment.*¹³⁹

International standards and guidance

Several international standards state the importance of hygiene in places of detention. They refer to both the personal hygiene of the prisoners as well as the general hygiene within the institution.

¹³⁹ ECHR (2020). *Factsheet - Detention conditions and treatment of prisoners*. European Court of Human Rights, May 2020. Available at: https://www.echr.coe.int/Documents/FS_Detention_conditions_ENG.pdf

The Mandela Rules outline that all parts of a prison regularly used by prisoners shall be properly maintained and kept scrupulously clean at all times (Rule 17). Every prisoner should be able to, and may be required to, have a bath or shower at an appropriate temperature and as frequently as necessary for the general hygiene (at least once a week) (Rule 16). Prisoners shall be provided with water and toilet articles necessary for health and cleanliness and facilities shall be provided for proper care of the hair and beard (and men being able to shave regularly) (Rule 18). All clothing, including underclothing, shall be clean and kept in proper condition and washed as often as necessary to maintain hygiene (Rule 19.2).

The Mandela Rules also highlight the role of health staff in maintaining hygienic conditions in the institution, by stating that *'the physician or competent public health body shall regularly inspect and advise the prison director on a number of issues including the hygiene and cleanliness of the institution and the prisoners'* (Rule 35.1b).

Also the European Prison Rules explicitly address hygiene similar to the Mandela Rules and in addition state that *'all parts of every prison shall be properly maintained and kept clean at all times'* and that *'when prisoners are admitted to prison the cells or other accommodation to which they are allocated shall be clean'* (Rule 19.1, 19.2).

Women have specific hygienic needs with regard to their reproductive health. The UN Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules) address this in Rule 5: *'The accommodation of women prisoners shall have facilities and materials required to meet women's specific hygiene needs, including sanitary towels provided free of charge and a regular supply of water to be made available for the personal care of children and women, in particular women involved in cooking and those who are pregnant, breastfeeding or menstruating.'*

ICRC has, in its publication on water, sanitation, hygiene and habitat in prisons, outlined some measures for maintaining personal hygiene.¹⁴⁰ They are very relevant to keep in mind for the health monitor assessing the hygiene in an institution. With regard to the amount of water that should be available to each detainee, ICRC states that the amount of water necessary for survival is 3-5 liters per person per day, and 10-15 liters per person per day to cover all minimum needs and remain in good health, as long as the other services and facilities are also in good working order. Furthermore, the publication states that *'each detainee must receive a minimum of 100 to 150 grams of soap per month. Regular washing with soap prevents the occurrence of many diseases, especially skin conditions and diarrheal diseases transmitted by the faecal-oral route. The cost of the soap will be more than offset by the savings made in keeping the detainees in good health. The detainees must be persuaded to wash their hands as a matter of course:*

- *after using the toilet;*
- *before eating;*
- *every time they have performed tasks such as sweeping up refuse, cleaning drains or unblocking pipes;*
- *every time there is reason to believe that they have been in contact with any pathogenic agent'.*

According to the publication, as a minimum, there should be 2,5 liters of water per minute to take a shower while 5 liters per person represents the minimum water necessary for washing oneself. There should be at least one shower available per 50 prisoners.

¹⁴⁰ ICRC (2013). *Water, sanitation, hygiene and habitat in prisons*. By Pier Giorgio Nembrini. Updated version from 2005. International Committee of the Red Cross, Geneva, 2013. Available at: https://www.icrc.org/eng/assets/files/other/icrc_002_0823.pdf

The publication also stresses the importance of kitchen hygiene and states that meals must be prepared and served in optimal hygiene conditions so as to minimize the risk of disease transmitted by food: *'the kitchen must be kept clean. Cleaning operations must be efficiently organized by the kitchen maintenance team. The floor must be swept every day; if it is cemented or tiled it should be disinfected with a chlorine solution once a week. It should also be washed regularly with detergent so as to remove grease. The individual dishes, utensils and cooking pots used for preparing meals must be thoroughly cleaned every time they are used and disinfected every week, either with a chlorine solution or, more simply, by plunging them into boiling water'*.

Moreover, the publication sets the following minimum specifications for Water, Sanitation and Hygiene (WASH) in places of detention:

- 1 tap per 100 detainees
- 1 toilet per 25 detainees
- 1 handwashing point per 50 detainees

In many developing countries, access to (clean) water and sanitation facilities in places of detention is limited and not meeting the requirements for WASH. For instance, coverage rates for WASH in places of detention have been shown to be much too low in many countries in Africa.¹⁴¹

Clean and sufficient sanitary facilities are essential to ensure the hygiene and dignity of the prisoners, as well as to avoid the transmission of certain infectious diseases as many infectious diseases contracted in prisons are transmitted by the faecal-oral route. See for more on sanitary facilities the chapter on accommodation, sanitation and ventilation in this Section.

The institution must also have sufficient showers installed, which are clean, accessible and safe. Prisoners should preferably have access to a shower every day and in accordance with the general principles of hygiene. Lack of water and inadequate access to showers affects personal hygiene and increases the risk of contracting diseases. Moreover, the arrangements in place to take a shower should not humiliate prisoners, for example, by obliging them to shower in public.¹⁴²

As a minimum, prisoners should have access to free soap, toothpaste, toilet paper and cleaning products, provided by the institution. In addition, prisoners should have access to products to take care of their hair, including shaving equipment. It is however important to note that hygiene requirements may never be used as an excuse for using disciplinary measures.¹⁴³

The specific hygiene needs of certain categories of detainees, in particular women, children and disabled people, must be taken into consideration and the necessary accommodation and extra measures must be provided. For instance, women should have access to sanitary napkins free of charge and to more regular bathing or showering when menstruating. Prisoners should not have to rely on their families for the basic products to maintain hygiene, nor shall they have to pay for them.¹⁴⁴

141 See: <http://www.ircwash.org/blog/water-sanitation-and-hygiene-are-crucial-prison-settings>

142 Coyle & Fair (2018). *A Human Rights Approach to Prison Management. Handbook for prison staff. Third edition*. International Centre for Prison Studies, 2018. Available at: https://www.prisonstudies.org/sites/default/files/resources/downloads/handbook_3rd_ed_english_v5_web.pdf

143 For instance, Mandela Rule 18.2 should not be used as an excuse to shave the heads of all prisoners.

144 APT Detention Focus. *Sanitary facilities and personal hygiene*. Available at: https://apt.ch/detention-focus/en/detention_issues/47/

Kitchen facilities should be kept clean and hygienic. Standards should be set and known to all prisoners, and prison staff should ensure that these standards are being kept. Poor hygiene in kitchens can lead to a variety of food-borne diseases, often with symptoms of diarrhea and fever.

It is important that prisoners are aware of the importance of personal as well as collective hygiene in the institution. Periodical hygiene education on selected relevant topics is therefore key to maintain healthy behaviour of prisoners (see also the chapter on health promotion and disease prevention in Section 3).

Of special interest to the health monitor would be the hygiene in the prison health clinic, including the hygiene in the facilities, of the equipment, and of the procedures.

Monitoring methodology

The health monitor should assess the hygiene in the institution and the prison (health) service's approach to hygiene. Are there examples of poor hygiene in this place of detention that could amount to ill-treatment or torture?

When interviewing the prison management, the monitor could ask into the compliance of the institution with international standards and guidance, such as the ICRC's specifications regarding WASH in places of detention (i.e. 1 tap per 100 detainees, 1 toilet per 25 detainees, and 1 handwashing point per 50 detainees). The monitor could also ask management about their approach with regard to maintaining and promoting hygiene in the institution and whether they collaborate with the health clinic on this.

Interviews with prisoners could focus on their assessment of the hygiene in the institution and their access to a toilet, bathing facilities, and basic toiletries. Female prisoners should be asked about their access to sanitary napkins and to bathing facilities while menstruating. Prisoners could also be asked about the possibility to wash their clothes.

Prison health professionals should be asked about their role in maintaining and promoting hygiene in the institution. For instance, do they inspect the hygiene of the facilities and do they report problems to management? Also, do they have a role in educating prisoners on how to maintain hygiene?

Also the interviews with prison guards should focus on their role in maintaining and promoting hygiene in the institution. They could also be asked about the prisoners' access to a toilet, bathing facilities and basic toiletries as well as procedures to keep the kitchen clean (in institutions where prisoners have access to a kitchen and can prepare meals themselves).

The monitor will get a lot of information on cleanliness and hygiene from merely observing the facilities and dorms in the institution. He/she should assess whether the institution smells clean and fresh and whether dorms, toilet, bathing, kitchen facilities are clean. He/she could for instance open a fridge in the kitchen and assess its cleanliness. Also checking the cleanliness of the prison health clinic is important.

The institution may have written instructions for prison (health) staff and/or prisoners on how to maintain good hygiene in the institution, for instance on good practices with regard to washing hands and keeping the dorms clean. There may also be training materials available which address maintaining and promoting hygiene in the institution.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

ICRC (2013). *Water, sanitation, hygiene and habitat in prisons*. By Pier Giorgio Nembrini. Updated version from 2005. International Committee of the Red Cross, Geneva, 2013. Available at: https://www.icrc.org/eng/assets/files/other/icrc_002_0823.pdf

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

4.3. Nutrition

As defined by the World Health Organization, nutrition is the intake of food, considered in relation to the body's dietary needs. Good and sufficient nutrition is a cornerstone of good health and well-being. Poor nutrition can lead to, for instance, reduced immunity to diseases, impaired physical and mental development, and reduced energy and productivity.¹⁴⁵

While the term nutrition refers to the metabolic impact on individuals of what they eat, food refers to edible items.¹⁴⁶

The quality and quantity of the food available in a place of detention has a big influence on the quality of a prisoner's life. The availability of safe and healthy food as well as drinking water is essential in maintaining and improving prisoners' health and in empowering them. Besides nutrition being essential for prisoners' health, it can help in prisoners' resettlement by providing training and work opportunities. In some places of detention, prisoners prepare their own food, either in a central prison kitchen or individual/in small groups,¹⁴⁷ while most use on-site catering companies.

Adequate nutrition should be considered one of prisoners' basic human rights. Healthy, nutritious meals will enable them to maintain or improve their health, and to take any necessary medication properly. Also, vulnerable population groups in places of detention – such as pregnant and breastfeeding women, substance users, juveniles and elderly people – have specific dietary requirements that need to be met. Also prisoners with certain health conditions may need special diets. What is offered to prisoners should be in line with the country's government's recommendations on healthy eating and take into account the special dietary requirements of some persons.

Prison administrations should provide all prisoners with sufficient food and drinks to ensure that they do not suffer from hunger or illnesses associated with under-nourishment and poor nutrition. Even places of detention in countries where the general population does not get enough food, cannot overrule this responsibility, because by depriving people from their liberty the state has the obligation to care for them properly. In very poor countries, prisoners unfortunately often rely on their relatives to bring food into the place of detention for them.

Relevance to preventive monitoring

The prison authorities have an obligation to meet the nutritional needs of prisoners. Failure to comply with this requirement may constitute a form of cruel, inhuman or degrading treatment, or even torture.

Prisoners should never be punished by deprivation or restriction of food and drinks. The reduction of food or drinks to prisoners as a form of punishment amounts to ill-treatment and in severe cases to torture. Moreover, prisoners who undergo a disciplinary sanction, such as isolation, should receive the same meals and drinks as other prisoners.

145 Website of the World Health Organization – Nutrition. Available at: <https://www.who.int/topics/nutrition/en/>

146 ICRC (2016). *Health care in detention. A practical guide*. International Committee of the Red Cross, Geneva, 2016. Available at: https://shop.icrc.org/health-care-in-detention-a-practical-guide.html?__store=default&_ga=2.52141101.545157892.1571396163-1731022843.1567763882

147 See for an example in Denmark: <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/focus-areas/nutrition>

Manipulation of food supply has been a tool for physiological manipulation during interrogation and detention for a long time.¹⁴⁸ In some countries, including the USA, detainees may get served 'nutrалоaf'¹⁴⁹ or another form of deliberately bland and repetitive diet when they are punished, for instance because of assaulting a prison staff member or fellow prisoner. Even when the nutritional value of such food is found to be in line with national standards, its taste and appearance is often so disgusting that it causes prisoners not to eat sufficiently. This treatment of prisoners is humiliating and degrading and should be prohibited. Fortunately, during the past years, the use of nutrалоaf is on the decline in the USA following years of lawsuits around the country.¹⁵⁰

The food available to prisoners is often a topic of their complaints. In many countries and institutions, prisoners are dissatisfied with the quality and/or quantity and/or the variety of the food they get served. These complaints may very well be justified but the cases often do not amount to ill-treatment or torture. There are however exceptions. For instance, Muslim prisoners being forced to eat pork and drink alcohol should surely be classified as a form of ill-treatment or even torture.

Food deprivation can be defined as the total or partial restriction of food.¹⁵¹ This can either be intentional or as a result of poor resources. Food deprivation either as a form of torture or as a result of poor prison conditions has been documented in China, USA, Turkmenistan, Sudan, Russia, Italy, Japan, Zimbabwe, Mozambique, Sudan, Gabon, Palestine, Tanzania and likely occurs in many more countries across the world.¹⁵²

Intentional water deprivation, either as a form of torture or as a result of poor prison conditions, has been documented in British-controlled detention facilities in southeast Iraq (2003-2008), in Michigan (USA), in Tanzanian prisons, and among Lebanese prisoners detained by Israeli forces (1981-1999). Inadequate provision of drinking water may have several health consequences for the individual and may have fatal consequences.¹⁵³

The European Court of Human Rights has received many cases relating to poor nutrition for prisoners and some of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following case is an example of a case judged by the Court as a violation of article 3:

Ebedin Abi v. Turkey 13 March 2018 *The applicant, who suffered from type 2 diabetes (abnormally high blood glucose levels) and from coronary artery disease, complained about his diet while he was in detention and, in particular, of not being provided with meals compatible with the diet that doctors had prescribed for him, and of a deterioration in his health as a result.*

The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention, finding that the Turkish authorities had not taken the necessary measures to protect the applicant's health and well-being and had failed to ensure that his conditions of detention were adequate and respected his human dignity. With regard to the alleged deterioration in the ap-

148 O'Mara SM (2015). *Why torture doesn't work: the neuroscience of interrogation*. Harvard University Press, 2015. P.322.

149 See: <https://en.wikipedia.org/wiki/Nutrалоaf>

150 See for example: <https://www.prisonlegalnews.org/news/2016/mar/31/use-nutrалоaf-decline-us-prisons/>

151 UN (2004). *Istanbul Protocol: manual on the effective investigation and documentation of torture and other cruel, inhuman, or degrading treatment or punishment*. United Nations, New York, 2004. p.76. Available at: <https://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

152 DIGNITY (2018). *Factsheet: Deprivation of food*. DIGNITY Danish Institute against Torture, Denmark, 2018. Available at: <https://dignity.dk/en/dignitys-work/health-team/torture-methods/deprivation-of-food/>

153 DIGNITY (2018). *Factsheet: Deprivation of water*. DIGNITY Danish Institute against Torture. Available at: <https://dignity.dk/en/dignitys-work/health-team/torture-methods/deprivation-of-water/>

*plicant's health as a result of his inability to follow the diet prescribed by doctors, the Court observed that the applicant had made use of all the available remedies in order to raise before the national authorities his complaints concerning the incompatibility of the meals served with his diet and the deterioration in his health allegedly linked to his food intake. The national authorities had failed to respond adequately to his repeated requests. Moreover, in view of the fact that persons in detention were unable to obtain medical treatment whenever they saw fit and in a hospital of their own choosing, the Court considered that the domestic authorities should have arranged for a specialist to study the standard menu offered by the prison and for the applicant to undergo a medical examination at the same time specifically geared to his complaints. In reality, the authorities had not sought to establish whether the food being provided to the applicant was suitable or whether the failure to adhere to the diet prescribed for him had had an adverse impact on his health.*¹⁵⁴

International standards and guidance

Mandela Rule 22 states that 'Every prisoner shall be provided by the prison administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served' and that 'drinking water shall be available to every prisoner whenever he or she needs it'. Rule 43 further prohibits the 'reduction of a prisoner's diet or drinking water' as a disciplinary measure or restriction.

The European Prison Rules include more specific standards and requirements relating to food and nutrition in prison settings. They state that (Rule 22):

'22.1 Prisoners shall be provided with a nutritious diet that takes into account their age, health, physical condition, religion, culture and the nature of their work.

22.2 The requirements of a nutritious diet, including its minimum energy and protein content, shall be prescribed in national law.

22.3 Food shall be prepared and served hygienically.

22.4 There shall be three meals a day with reasonable intervals between them.

22.5 Clean drinking water shall be available to prisoners at all times.

22.6 The medical practitioner or a qualified nurse shall order a change in diet for a particular prisoner when it is needed on medical grounds'.

Children and juveniles have specific nutritional needs due to their physical and mental developmental phase in life. The United Nations Rules for the Protection of Juveniles Deprived of their Liberty state in Rule 37 that 'every detention facility shall ensure that every juvenile receives food that is suitably prepared and presented at normal meal times and of a quality and quantity to satisfy the standards of dietetics, hygiene and health and, as far as possible, religious and cultural requirements. Clean drinking water should be available to every juvenile at any time'.¹⁵⁵

Specific requirements also prevail for prisoners who are ill and have a weakened immune system, for instance prisoners with diabetes and prisoners living with HIV/AIDS. The WHO Regional Office for Europe stresses in its publication on Prisons and Health that nutrition support needs to be available for prisoners living with HIV/AIDS: 'People living with HIV require food supplements that complement their diet to enable them to meet their total micronutrient and macronutrient needs.

¹⁵⁴ ECHR (2019). *Factsheet – Prisoners' health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

¹⁵⁵ UN (1990b). *UN Rules for the Protection of Juveniles Deprived of their Liberty*. United Nations General Assembly, 1990. Available at: <http://www.un.org/documents/ga/res/45/a45r113.htm>

In particular, fresh fruits and vegetables should complement the staple foods. A nutritionist should advise the prison authorities on the specific needs of patients without breaching confidentiality about the disease'.¹⁵⁶ Also for prisoners with a chronic disease, such as a heart problem or diabetes, an appropriate diet controlled by the prison health staff is very important for their health. Similarly, pregnant or nursing women and their children must receive a suitable diet for their situation.

Many countries have national regulations in place addressing minimum standards for food and nutrition in places of detention. These regulations are often part of national prison law rather than food law.

In developed countries, many prisons support the requirements of specific religions, as well as vegetarianism.¹⁵⁷ Menus obeying to specific religious requirements should be available for religious prisoners following a specific diet, and balanced vegetarian menus should be available for prisoners who do not eat meat. Menu selection must be determined together with the health staff, preferably including nutritionists, while the nutritional value and overall quality of meals served in prison must be evaluated and controlled by independent experts.

While prison food in many developed countries is considered to be adequate to maintain health, this is often a different story in developing countries. However, initiatives are taken in countries worldwide aiming to ensure sufficient and nutritious food for the prison population. An example can be found in Malawi:

In Malawi the prison administration, working closely with the non-governmental organization Penal Reform International, has developed a project to upgrade the prison farms and increase their productivity. This is helping the country's prisons to move towards self-sufficiency in food production, to feed prisoners and staff and their families as well as train prisoners in agricultural methods.¹⁵⁸

Supporting and ensuring safe and healthy food and drinks in prison will help to prevent under-nourishment and diet-related diseases and promote better overall health of prisoners. Considerable benefits can be achieved when prison (health) services make an effort to promote healthy lifestyles and facilitate healthy eating by prisoners.

Monitoring methodology

When monitoring the nutrition in a place of detention, the health monitor should look into all sources of information available to his/her, including interviews with prison management, prisoners, prison health staff and prison guards, observations and documents.

The monitor should talk with the prison management about the general guidelines and procedures with regard to food and nutrition in the institution, for example the food budget per prisoner, how the preparation and distribution of food to the prisoners is arranged, whether there are minimum requirements for the nutrition to be provided to prisoners (national standards?) and if these guidelines are adhered to, and what initiatives are taken by management or the prison health service to promote healthy eating.

Interviews with prisoners could give the monitor information on how they experience the food and drinks available to them. They could also be asked about the way they get their meals (are

¹⁵⁶ WHO/Europe (2014). **Prisons and Health**. World Health Organization Regional Office for Europe, Copenhagen, Denmark. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf?ua=1

¹⁵⁷ Ogden and Rebein (2001). Do Prison Inmates Have a Right to Vegetarian Meals? *Vegetarian Journal* March/April 2001. Available at: <https://www.vrg.org/journal/vj2001mar/2001marprison.htm>

¹⁵⁸ Coyle & Fair (2018). *A Human Rights Approach to Prison Management. Handbook for prison staff. Third edition*. International Centre for Prison Studies, 2018. Available at: https://www.prisonstudies.org/sites/default/files/resources/downloads/handbook_3rd_ed_english_v5_web.pdf

they provided to them or do they prepare them themselves?). Prisoners with special dietary requirements, related to their health or religious beliefs, should be asked whether these are taken into account during their stay in the institution and how this is done.

Prison health staff should be asked to elaborate on their role in the food and drinks provided to the prisoners. For instance, do they have a role in setting the menus, in ensure adequate nutrition for prisoners with special dietary requirements, and in promoting healthy eating?

Interviews with prison guards should foremost concentrate on their role in the distribution of food and drinks to the prisoners and in promoting healthy eating among them.

Observations are important when monitoring nutrition in the institution. The health monitor could for instance look in the fridges and check whether the food looks fresh and nice and whether the variety is in line with the government's recommendations on healthy eating. The monitor could arrange to see and taste the food that the prisoners get served that day.

Last but not least, the monitor should look into any documents available addressing nutrition. These could for instance include nutritional guidelines (by the government or internally by the institution), budgets, menus, registers, and promotion materials such as posters or brochures promoting healthy eating.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

APT. Webpage: *Detention Focus. Food and Water*. Association for the Prevention of Torture. Available at: https://www.apr.ch/detention-focus/en/detention_issues/44/

CoE (2006). *European Prison Rules*. Council of Europe, Strasbourg, 2006. Available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

Coyle & Fair (2018). *A Human Rights Approach to Prison Management. Handbook for prison staff. Third edition*. International Centre for Prison Studies, 2018. Available at: https://www.prison-studies.org/sites/default/files/resources/downloads/handbook_3rd_ed_english_v5_web.pdf

DIGNITY (2018). *Factsheet: Deprivation of food*. DIGNITY Danish Institute against Torture. Available at: <https://dignity.dk/en/dignitys-work/health-team/torture-methods/deprivation-of-food/>

DIGNITY (2018). *Factsheet: Deprivation of water*. DIGNITY Danish Institute against Torture. Available at: <https://dignity.dk/en/dignitys-work/health-team/torture-methods/deprivation-of-water/>

ICRC (2016). *Health care in detention. A practical guide*. International Committee of the Red Cross, Geneva, 2016. Available at: https://shop.icrc.org/health-care-in-detention-a-practical-guide.html?__store=default&_ga=2.52141101.545157892.1571396163-1731022843.1567763882

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, Denmark. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf?ua=1

4.4. Accommodation, sanitation and ventilation

This chapter addresses the accommodation, sanitation and ventilation in a place of detention and how the health professional could monitor them with regard to their impact on prisoners' health.

When referring to accommodation in this chapter, this includes both the conditions in the common areas of the institution as well as of the cell or dorm a prisoner is placed in. The conditions of the accommodation have a considerable impact on how a prisoner will experience daily life in prison. When a prison is overcrowded, this has severe implications for prisoners' daily life and interaction, sleeping patterns, hygiene and privacy. For instance, if only one toilet is available for 24 prisoners, while it was supposed to be for 12 prisoners, this has serious consequences for privacy, hygiene and comfort.

Sanitation refers to public health conditions related to clean drinking water, bathing and hand-washing facilities, and adequate treatment and disposal of human excreta and sewage. As clean drinking water has already been addressed in the previous chapters on hygiene and nutrition, this chapter will focus on adequate treatment and disposal of human excreta and sewage (toilets and buckets) and bathing and handwashing facilities. Sufficient sanitary facilities that are in good condition, kept clean, and easy to access are essential to ensure the hygiene and dignity of the prisoners, as well as to limit the transmission of certain communicable diseases.

Ventilation in this chapter refers to the process of replacing air to provide a good indoor air quality. This impacts on the movement of air between the environment and the lungs of individuals via inhalation and exhalation. Adequate ventilation in places of detention is another element which is essential in the prevention of the spread of communicable diseases (such as Tuberculosis or influenza) and in ensuring healthy living conditions within the institution.

Relevance to preventive monitoring

The failure of prison authorities to ensure adequate accommodation, sanitation and ventilation may amount to inhuman and degrading treatment. For instance, poor accommodation facilities may constitute an aggravated form of 'pain or suffering arising only from, inherent in or incidental to lawful sanctions' (UNCAT paragraph 1), and as such qualify as ill-treatment. Situations of severe overcrowding combined with unhealthy conditions in the accommodation and a lack of space may constitute a form of ill-treatment. If poor accommodation is used intentionally with a purpose (such as extortion of money) and with the involvement of staff members, it may amount to torture.

Regular access to sanitary facilities which are clean and function well, is essential to maintain people's dignity. When access is not guaranteed, the everyday life of prisoners is seriously adversely affected. Not taking into account a person's basic human needs may constitute ill-treatment.

Also poor ventilation in the institution or cell/dorm may amount to ill-treatment. This is for instance the case when prisoners get sick due to insufficient or no fresh air and a lack of oxygen.

The European Court of Human Rights has received many cases relating to poor accommodation, sanitation and/or ventilation for prisoners and some of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following case is an example of a case judged by the Court as a violation of article 3:

Florea v. Romania 14 September 2010. In 2002 the applicant, who suffered from chronic hepatitis and arterial hypertension, was imprisoned. For approximately nine months he shared a cell with between

110 and 120 other prisoners, with only 35 beds. According to the applicant, 90% of his cellmates were smokers. The applicant complained in particular of overcrowding and poor hygiene conditions, including having been detained together with smokers in his prison cell and in the prison hospital.

The Court observed in particular that the applicant had spent in detention approximately three years living in very cramped conditions, with an area of personal space falling below the European standard. As to the fact that he had to share a cell and a hospital ward with prisoners who smoked, no consensus existed among the member States of the Council of Europe with regard to protection against passive smoking in prisons. The fact remained that the applicant, unlike the applicants in some other cases the Court had previously dealt with, had never had an individual cell and had had to tolerate his fellow prisoners' smoking even in the prison infirmary and the prison hospital, against his doctor's advice. However, a law in force since June 2002 prohibited smoking in hospitals and the domestic courts had frequently ruled that smokers and non-smokers should be detained separately. It followed that the conditions of detention to which the applicant had been subjected had exceeded the threshold of severity required by Article 3 (prohibition of inhuman or degrading treatment) of the Convention, in violation of this provision.¹⁵⁹

International standards and guidance

The Mandela Rules include several Rules specifically referring to the accommodation, sanitation and ventilation in an institution (Rules 12-17, 21). They stress the need of appropriate sleeping accommodation, taking into account 'cubic content of air, minimum floor space, lighting, heating and ventilation' (Rule 13). Windows shall be large enough to allow for the entrance of fresh air 'whether or not there is artificial ventilation' (Rule 14.1). Sanitary installations need to be 'adequate to enable every prisoner to comply with the needs of nature when necessary and in a clean and decent manner' (Rule 15) and bathing and shower installations shall be provided and suitable (Rule 16). 'All parts of a prison regularly used by prisoners shall be properly maintained and kept scrupulously clean at all times' (Rule 17). Every prisoner shall be provided with a separate bed and separate and sufficient bedding which is 'clean, kept in good order and changed enough to ensure its cleanliness' (Rule 21).

The United Nations Rules for the Protection of Juveniles Deprived of their Liberty include rules addressing specifically the accommodation of juvenile prisoners¹⁶⁰, while the UN Rules for the Treatment of Women Prisoners and Non-Custodial Sanctions for Women Offenders (the Bangkok Rules) address the specific needs of female prisoners.¹⁶¹

Up to recently, international instruments did not explicitly specify space (i.e. a minimum floor or cubic area) for each prisoner. First in 2015, the European Committee for the Prevention of Torture published CPT standards on the living space per prisoner, which state the following minimum standards for personal living space:

- 6m² of living space for a single-occupancy cell + sanitary facility
- 4m² of living space per prisoner in a multiple-occupancy cell + fully-partitioned sanitary facility
- at least 2m between the walls of the cell

159 ECHR (2019). *Factsheet – Prisoners' health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

160 UN (1990). *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*. United Nations, 1990. Available at: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/JuvenilesDeprivedOfLiberty.aspx>

161 UN (2010). *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders*. United Nations, 2010. Available at: https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf

- at least 2.5m between the floor and the ceiling of the cell¹⁶²

ICRC has outlined the following technical specifications (minimum standards) with regard to the sanitation in places of detention:

- Toilets: 1:25 persons. A minimum of one toilet should be provided for each accommodation area that houses up to 25 detainees. Where single cells are provided, each cell should contain a toilet. In multiple occupancy cells or dormitories, some cultures will be accustomed to having a much higher number of toilet and shower fixtures.
- Showers: 1:50 persons and 3 showers per week (minimum and according to local climatic conditions).
- Taps in latrines: 1 for each toilet block for washing hands.¹⁶³

ICRC has also recommended that *'the size of the cell opening be at least 1/10 of the cell's surface area, to allow renewal of air and proper lighting'*.¹⁶⁴

In many (in particularly low income) countries, prison overcrowding is a constant and serious problem making life very difficult for the prisoners and making it impossible for authorities to keep appropriate control. Most often the 'strong prisoners' take over this control function. This, in combination with very different conditions in various sections of the prison, forms the basis for a black market where accommodation has a price. In this case the best/least overcrowded dormitories are the most expensive and those housing the most violent prisoners being much cheaper, leaving a small space on the floor in unattractive dormitories for those who cannot pay. In many places, such trading is pervasive and involves all levels of staff members as well as the 'strong prisoners'. Trading of accommodation may develop into extortion of money involving the families of the 'weaker prisoners'. This may further lead to torture of some prisoners – committed by the 'stronger ones' with acquiescence of staff members – if they do not adapt themselves to the ruling order. It is important that monitors are aware of such mechanisms that may work in manners that are more subtle, but nevertheless are a gross violation of the prisoners' rights and often are related to violence.

Considerations relating to available space must always be made alongside other factors, such as the state of sanitation, the time spent out of the cell, the availability of common facilities, and overcrowding.

Prisoners should have unrestricted access to sanitary facilities, including toilet facilities, shower or bathing facilities and access to clean water. They should have access to the needed quantity of clean water. Available water supply should cover the drinking water needs, and in addition be sufficient for food preparation, personal hygiene, cleaning, watering and any other basic requirements.

The sanitary facilities and arrangements in place should adhere to prisoners' dignity and self-respect and should not humiliate them by, for example, obliging them to use the toilet or shower in public. The special needs of female prisoners with regard to sanitary facilities and arrange-

162 CPT (2015). *Living space per prisoner in prison establishments*. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Strasbourg, 2015. Available at: <http://www.cpt.coe.int/en/working-documents/cpt-inf-2015-44-eng.pdf>

163 ICRC (2013). *Water, sanitation, hygiene and habitat in prisons*. By Pier Giorgio Nembrini. Updated version from 2005. International Committee of the Red Cross, Geneva, 2013. Available at: https://www.icrc.org/eng/assets/files/other/icrc_002_0823.pdf

164 ICRC (2016). *Health care in detention. A practical guide*. International Committee of the Red Cross, Geneva, 2016. Available at: https://shop.icrc.org/health-care-in-detention-a-practical-guide.html?__store=default&ga=2.52141101.545157892.1571396163-1731022843.1567763882

ments should be provided for, including free provision of sanitary napkins and more frequent access to showering or bathing if required, e.g. during menstruation.

Toilets or latrines should be accessible to all prisoners and preferably directly accessible from the cell, separated by a door or partition. However, in many institutions, cells do not include toilets or latrines and prisoners have to ask a staff member for getting access. This should always be granted with as little delay as possible. In all cases, people in detention must be able to go to the toilet when they need to and with their dignity being respected.¹⁶⁵ There must be sufficient showers so that detainees can use them as often as necessary. Communal shower areas may present an area of risk for certain vulnerable detainees, including LGBTI prisoners, which should be kept in mind and abuses should be prevented as much as possible.

Proper ventilation should be guaranteed to allow prisoners (and staff members) to breathe normally, controlling the humidity level in the living spaces and getting rid of bad smells. Climate is of course an important factor and the institution needs to ensure as much as possible a medium temperature and good air circulation within all areas of the institution, regardless of the temperature outside.

Unfortunately, many prisons worldwide fall short when it comes to adequate provisions with regard to accommodation, sanitation and ventilation. Overcrowding, insufficient resources and poor overall conditions contribute to a prison being an unhealthy environment which enhances the spread of disease and does not adhere to a person's dignity and right to privacy.

Efforts should be made to improve conditions to adhere to prisoners' dignity, but also in interest of personal and public health. For instance, poor ventilation is demonstrated to contribute significantly to the spread of tuberculosis. A study in 2015 showed that improved ventilation had a clear positive impact on reducing the spread of TB. The study demonstrated in three prisons in Brazil that improving ventilation to the standards set by the World Health Organization decreased TB transmission by 38.2%, whereas optimizing cross-ventilation reduced transmission by 64.4%.¹⁶⁶

Monitoring methodology

Monitoring the accommodation, sanitation and ventilation is a key part of monitoring health in places of detention. These prison health factors have a severe influence on prisoner's dignity and health, whether it is contamination with a communicable disease due to poor sanitation or ventilation, or lack of sleep due to lack of beds and severe overcrowding. It is essential to keep in mind that the conditions offered to a prisoner must be compatible with human dignity. It should guarantee safety and the rights of all prisoners and at the same time ensure that each prisoner has some privacy.

The monitor should use all information sources available to him/her in order to make a thorough assessment of the accommodation, sanitation and ventilation and of whether they are in line with international standards and guidance.

The management of the institution could be asked questions to assess whether the institution complies with international standards and guidance, such as the CPT standards on available living space and the ICRC minimum standards on sanitation. The management could be asked

165 APT. *Detention Focus. Sanitary facilities and personal hygiene*. Available at: https://apt.ch/detention-focus/en/detention_issues/47/

166 Urrego et al. (2015). The Impact of Ventilation and Early Diagnosis on Tuberculosis Transmission in Brazilian Prisons. *Am J Trop Med Hyg*, 2015 Oct;93(4):739-46. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4596592/>

about the overall conditions in the institution, their assessment thereof, and challenges in addressing problems and shortcomings.

By interviewing prisoners, the monitor will gain insight into their experience living in the institution with regard to the accommodation, sanitary facilities and ventilation. Prisoners could for instance be asked whether they have unrestricted access to a toilet and a (warm) shower and to clean water. They could also be asked for their assessment of the cleanliness of the accommodation and sanitary facilities and of the air quality in their dorm and other areas of the institution.

Interviews with prison health staff should focus on the role of prison health professionals in ensuring living conditions in the institution that are respecting prisoners' dignity and health. Questions could for instance include whether the prison health professionals regularly assess the conditions and how they report and follow-up on their findings. They could also be asked whether there have been disease outbreaks due to poor standards and how this was followed up on (e.g. was anything changed?)

Prison guards may be able to give additional insight into procedures of prisoners having access to sanitary facilities. They could also be asked whether there have been any incidents in the sanitary facilities, such as LGBTI prisoners being threatened or abused, and how this was followed up on.

Observations during the monitoring visit are important and will give the monitor a lot of information about the conditions, such as available space, overcrowding, access to and hygiene of the sanitary facilities, and air quality (for instance, does it smell badly in some areas or does it feel humid?).

The final information source which the health monitor should use during his/her monitoring visit are documents, including any written instructions, registers and medical records that can be accessed. These could for instance include any written instructions on cleaning sanitary facilities, or registers on outbreaks of communicable diseases (which could be caused by poor conditions of accommodation, sanitation or ventilation).

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

APT. *Detention Focus. Material conditions of detention*. Website: <https://www.apr.ch/detention-focus/en/themes/4/?vg=-1>

CPT (2015). *Living space per prisoner in prison establishments. CPT Standards*. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Strasbourg, 2015. Available at: <https://rm.coe.int/16806cc449>

ICRC (2013). *Water, sanitation, hygiene and habitat in prisons*. By Pier Giorgio Nembrini. Updated version from 2005. International Committee of the Red Cross, Geneva, 2013. Available at: https://www.icrc.org/eng/assets/files/other/icrc_002_0823.pdf

ICRC (2016). *Health care in detention. A practical guide*. International Committee of the Red Cross, Geneva, 2016. Available at: https://shop.icrc.org/health-care-in-detention-a-practical-guide.html?__store=default&_ga=2.52141101.545157892.1571396163-1731022843.1567763882

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UNODC (2013). *Handbook on strategies to reduce overcrowding in prisons*. United Nations Office on Drugs and Crime, New York, 2013. Available at: https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf

4.5. Use of solitary confinement

Solitary confinement refers to a form of imprisonment distinguished by living in single cells with little or no meaningful contact to others. Other terms for solitary confinement include segregation, isolation or lockdown.

Solitary confinement may occur in many different forms. The most extreme form of solitary confinement is when a prisoner is held entirely alone and is subject to sensory deprivation by lack of access to light, sound and/or fresh air. This can be referred to as solitary confinement in 'dark cells'. Another, slightly less extreme, form of solitary confinement occurs when a prisoner is held in a single cell with access to light and air and can hear prisoners and staff moving in adjacent areas of the institution. Less extreme forms of solitary confinement are used more frequently.

Many countries around the world use solitary confinement more routinely and for longer periods of time and excessive use of solitary confinement is a major concern. For instance, in the United States, 80.000-100.000 individuals are estimated to be held in some form of isolation.¹⁶⁷ And another example country, New Zealand, saw a 151% rise in the use of solitary confinement over the five-year period up until 2016, compared to a 16% rise in the prison population.¹⁶⁸

The practice of solitary confinement, however, varies significantly across countries and even individual detention facilities when it comes to what justifies solitary confinement and who can be subjected to it, time limitations on solitary confinement, and conditions of solitary confinement. Solitary confinement may be used as a form of punishment, or it may be used as a preventive measure as a way of ensuring the security of the institution with more vague indications, in relation to a prisoner's criminal investigation, or as a way of protecting a prisoner. Protection can be against the prisoner him/herself, in case of risks for self-harming or committing suicide, or against other prisoners in case the prisoner is threatened by others. In case a prisoner is kept in solitary confinement for protection against him/herself, he/she will often be observed by prison staff, either live or through a camera in the cell. The cells where these prisoners are kept are often referred to as 'observation cells'. They may have 'soft' walls and only a mattress on the ground, to protect the prisoner from harming him/herself or committing suicide.

Regardless of the form of and reason for the solitary confinement, evidence shows that it may have adverse effects on the physical and psychological status of the prisoner.¹⁶⁹ According to a review study in 2017, recent studies have identified a wide range of adverse psychological reactions that frequently occur in solitary confinement. The specific symptoms may include:

- stress-related reactions (such as decreased appetite, trembling hands, sweating palms, heart palpitations, and a sense of impending emotional breakdown)
- sleep disturbances
- heightened levels of anxiety and panic
- irritability, aggression, and rage
- paranoia, ruminations, and violent fantasies
- cognitive dysfunction, hypersensitivity to stimuli, and hallucinations

167 PRI. *Website key acts on solitary confinement*. Penal Reform International. Available at: <https://www.penalreform.org/issues/prison-conditions/key-facts/solitary-confinement/>

168 PRI (2018). *Global Prison Trends 2018*. Penal Reform International and Thai Institute of Justice, 2018. Available at: https://cdn.penalreform.org/wp-content/uploads/2018/04/PRI_Global-Prison-Trends-2018_EN_WEB.pdf

169 DIGNITY (2018). *Fact sheet on solitary confinement*. DIGNITY Danish Institute against Torture, 2018. Available at: <https://dignity.dk/en/dignitys-work/health-team/torture-methods/solitary-confinement/>

- loss of emotional control, mood swings, lethargy, flattened affect, and depression
- increased suicidality and instances of self-harm
- paradoxical tendencies to further social withdrawal.^{170 171}

Relevance to preventive monitoring

The UN Committee against Torture, the CPT and the UN Special Rapporteur on Torture have all paid particular attention to the use of solitary confinement which under certain circumstances can be regarded as a form of ill-treatment or torture.

The European Court of Human Rights has received many cases related to the use solitary confinement. The below example shows how placement of a prisoner in solitary confinement can amount to ill-treatment or even torture, and is a violation of article 3 of the Convention of Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*):

X v. Turkey. 9 October 2012. This case concerned a homosexual prisoner who, after complaining about acts of intimidation and bullying by his fellow inmates, was placed in solitary confinement for over 8 months in total.

*The Court took the view that these detention conditions had caused him mental and physical suffering, together with a feeling that he had been stripped of his dignity, thus representing "inhuman or degrading treatment" in breach of Article 3 of the Convention. It further found that the main reason for the applicant's solitary confinement had not been his protection but rather his sexual orientation. It thus concluded that there had been discriminatory treatment in breach of Article 14 (prohibition of discrimination) of the Convention.*¹⁷²

The imposition of solitary confinement can include indefinite or prolonged solitary confinement, but can also include corporal or collective punishment, the reduction of a prisoner's diet or drinking water, or the placement of a prisoner in a dark or constantly lit cell. Misuse of solitary confinement in these ways can constitute a form of torture or ill-treatment and as such must be prohibited in line with international human rights law.¹⁷³

The European Committee for the Prevention of Torture, CPT, has worked consistently towards the minimization of solitary confinement because of the *'mental, somatic and social damage'* it can inflict and also *'given the opportunity it can provide for the deliberate infliction of ill-treatment'*. Its reports and standards have been very influential. Particular attention has also been paid to the justifications, duration, detention conditions, impact, and procedural rights.¹⁷⁴

International standards and guidance

The use of solitary confinement is addressed in several international conventions, standards and declarations. International standards agree that solitary confinement should be used only in exceptional circumstances and that its use should be restricted or abolished.

170 Haney, C (2017). Restricting the Use of Solitary Confinement. *Annual Review of Criminology*. 1: 285–310. Available at: <https://www.annualreviews.org/doi/full/10.1146/annurev-criminol-032317-092326>

171 DIGNITY (2018). *Fact sheet on solitary confinement*. DIGNITY Danish Institute against Torture, 2018. Available at: <https://dignity.dk/en/dignitys-work/health-team/torture-methods/solitary-confinement/>

172 ECHR (2020). *Factsheet - Detention conditions and treatment of prisoners*. European Court of Human Rights, May 2020. Available at: https://www.echr.coe.int/Documents/FS_Detention_conditions_ENG.pdf

173 WMA (2019). *WMA Statement on Solitary Confinement*. World Medical Association, 2019. Available at: https://www.wma.net/policies-post/wma-statement-on-solitary-confinement/#.XcpPquAh_Mk.email

174 CPT (2011). *Solitary confinement of prisoners*. Council of Europe European Committee for the Prevention of Torture, 2011. Available at: <https://rm.coe.int/16806cccc6>

The Mandela Rules define solitary confinement as *'the confinement of prisoners for 22 hours or more a day without meaningful human contact'* and prolonged solitary confinement as *'solitary confinement for a time period in excess of 15 consecutive days.'* (Rule 44). In Rule 43, the Mandela Rules states that *'indefinite solitary confinement, prolonged solitary confinement and placement of a prisoner in a dark or constantly lit cell shall be prohibited.'* Mandela Rule 45 outlines that *'solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority.'*

The Basic Principles for the Treatment of Prisoners outline in Principle 7 that *'efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged'*.

The European Prison Rules state in Rule 60.5 that *'solitary confinement shall be imposed as a punishment only in exceptional cases and for a specified period of time, which shall be as short as possible'*.

According to the Mandela Rules, the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules), the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules), and the Special Rapporteur on Torture, solitary confinement should be prohibited for juveniles, pregnant women, women with infants, and for individuals with mental and/or physical disabilities when their conditions will be exacerbated by the confinement.

The international standards elaborate specifically on the role of health professionals in solitary confinement.

The Mandela Rules state in Rule 43.2 that *'the medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement'* and that *'the medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement.'*

The Mandela Rules further elaborate that health care staff should not have any role in the imposition of solitary confinement. They should however visit a person in solitary confinement on a daily basis to assess his/her physical and mental health and should have the authority to recommend the termination or necessary changes in the solitary confinement of the prisoner (Rule 46).

The World Medical Association published a statement on solitary confinement in 2014, which was updated in 2019.¹⁷⁵ In the statement it is clearly described that *'physicians should never participate in any part of the decision-making process resulting in solitary confinement, which includes declaring an individual as "fit" to withstand solitary confinement or participating in any way in its administration.'* Physicians should be guaranteed daily access to the prisoners in solitary confinement and enabled to act in full independence from the prison administration. It states that *'physicians have a duty to consider the conditions in solitary confinement and to raise concerns with the authorities if they believe that they are unacceptable or might amount to inhumane or degrading treatment. There should be clear mechanisms in place in each system to allow physicians to report such concerns.'*

175 WMA (2019). WMA Statement on Solitary Confinement. World Medical Association, October 2019. Available at: https://www.wma.net/policies-post/wma-statement-on-solitary-confinement/#.XcpPquAh_Mk.email

The role of the health professional in a place of detention is a difficult one when it comes to solitary confinement, knowing that solitary confinement can have serious detrimental effects on a person's mental health. It is not possible to assess if and when a person may experience negative health effects because of solitary confinement and the health professional should therefore always aim to minimize negative impacts on the health of the person, which could include ensuring that the authorities are adhering to law and regulations. Not recommending the discontinuation of solitary confinement of a person may in fact imply indirect endorsement of the measure, which constitutes a difficult dilemma for the health professional. The health professional should in no circumstances have a role in the imposition of the solitary confinement.

The international standards make clear that solitary confinement should only be used in very exceptional circumstances or where it is absolutely necessary for criminal investigation purposes, but that it is in by far most cases not an appropriate form of punishment/measure. There is an emerging consensus among correctional staff, mental health specialists, legal professionals and human rights organizations to drastically limit the use of solitary confinement.¹⁷⁶

Isolating prisoners have been linked with several adverse effects for their physical and mental health status (as outlined above). According to Shalev, the degree of harm inflicted on a prisoner when kept in solitary confinement depends on a number of factors, including:

- individual factors – such as personal background and pre-existing health problems
- environmental factors – i.e., physical conditions and provisions
- contextual factors, including:
 - the specific regime – such as time out of the solitary confinement cell, degree of human contact etc.
 - the context of the solitary confinement – such as punishment, own protection, voluntary/non-voluntary, political/criminal; and, its duration.¹⁷⁷

Solitary confinement in 'dark cells' should never be used and is an obvious form of torture. Solitary confinement in a single cell with access to normal light and air should only be used in highly exceptional circumstances for a very short period of time. In such cases, the prisoner should be carefully monitored on a daily basis by a medical professional. He/she should note any deterioration in the prisoner's physical or mental health in which case the solitary confinement should be ended immediately. Isolation beyond two weeks is prohibited by Rule 43 (1) (b) of the Mandela Rules. This should be viewed as '*a clear point of departure from which solitary confinement no longer constitutes a legitimate tool for State use regardless of the circumstances*', as stated by the former UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.¹⁷⁸

Besides solitary confinement as a form of punishment, some prison systems use solitary confinement to observe a prisoner with intentions to commit suicide. Although prisoners are placed in these types of cells out of the principle of protecting them against themselves, the conditions and possible health consequences of this type of solitary confinement need to be very closely watched by health professionals as well as health monitors.

176 Haney, C (2017). Restricting the Use of Solitary Confinement. *Annual Review of Criminology*. 1: 285–310. Available at: <https://www.annualreviews.org/doi/pdf/10.1146/annurev-criminol-032317-092326>

177 Shalev (2008). *A sourcebook on solitary confinement*. Mannheim Centre for Criminology, London School of Economics and Political Science, 2008. Available at: <http://www.cpt.coe.int/en/conferences/cpt25-Panel4-Shalev.pdf>

178 SRTUnited Kingdom 8,eden 93eden in 2015f Torture enuch as a fight involving weapons. Conversely, e imposition of isolation on womeSTSRbkklsagsaio, reply to questions raised by Member States during the Interactive Dialogue at the 66th Session of the UN General Assembly, 18 October 2011, p. 8; Report of the SRT (A/66/268, 5 August 2011), para. 26.

The institution should keep a register of the use of all forms of solitary confinement. The register should include information on the ID of persons kept there; the reasons for the decision; the date of entry and the date of ending; the authority that took the decision together with the decision of any appeal made; all dates for medical assessments prior to the start of the isolation and during the stay in isolation together with any medical recommendation.

Monitoring methodology

A health monitor should assess the issues within a place of detention related to the prison (health) service's approach to solitary confinement and the institution's compliance with international standards on the use of solitary confinement. The monitor should assess whether the way in which solitary confinement is used in the institution may amount to ill-treatment or torture, including gathering information and data on the use of and procedures around different forms of solitary confinement.

When interviewing the prison management, the monitor could for instance ask management about the role of the health professional in the imposition of solitary confinement and the assessment of prisoners in solitary confinement. Management could also elaborate on the procedures in relation to solitary confinement and on the rules and practices with regard to special groups, such as prisoners at risk of suicide or self-harming, those who request solitary confinement for own protection, and women/children/mentally ill prisoners.

Interviews with prisoners should include both prisoners who are or have been in solitary confinement themselves and other prisoners. Interviews with those who are or have been in solitary confinement could focus on the process around the imposition of the solitary confinement, the conditions of the solitary confinement cell, the daily life in solitary confinement and an assessment of how the solitary confinement may have affected the person and his/her health. Prisoners could also be asked whether they feel that certain groups of prisoners may be discriminately subjected to solitary confinement.

Prison health professionals should be asked about their role in solitary confinement, both in its imposition and in the assessment of prisoners who reside in solitary confinement (including recording of the results of their assessments). Prison health professionals could also elaborate on their challenges and (ethical) dilemmas with regard to the use of solitary confinement.

Prison guards are the ones in most frequent contact with prisoners and could be asked about their role, both in sending a person into solitary confinement and during solitary confinement. The interviews with prison guards could for instance focus on the access of prisoners in solitary confinement to fresh air and to daily activities.

During the monitoring visit, the monitor should assess the solitary confinement cells with regard to their hygiene, and standards as to space, light, ventilation, temperature and access to toilet and shower. If the institution has specific 'observation cells' for prisoners at risk of self-harming or committing suicide, these should be observed as well.

As the final information source, documents should be accessed. These include for instance written instructions on the use of (the different forms of) solitary confinement, and registers on their use. The monitor could also look into medical records of prisoners who are or have been in solitary confinement, to check whether anything has been noted in relation to the solitary confinement. This would include entries reflecting the attendance to and assessments by health professionals of prisoners in solitary confinement.

Information from the registers should be triangulated with information from the persons who have been subject to solitary confinement and with information from health professionals, including medical records.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

APT. *Webpage: Detention Focus. Solitary confinement*. Association for the Prevention of Torture. Available at: https://www.apr.ch/detention-focus/en/detention_issues/37/

CoE (2006). *European Prison Rules*. Council of Europe, Strasbourg, 2006. Available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

DIGNITY (2018). *Fact sheet on solitary confinement*. DIGNITY Danish Institute against Torture, 2018. Available at: <https://dignity.dk/en/dignitys-work/health-team/torture-methods/solitary-confinement/>

Shalev (2008). *A sourcebook on solitary confinement*. Mannheim Centre for Criminology, London School of Economics and Political Science, 2008. Available at: <http://www.cpt.coe.int/en/conferences/cpt25-Panel4-Shalev.pdf>

UN (1991). *Basic Principles for the Treatment of Prisoners*. United Nations resolution, adopted by the General Assembly, 28 March 1991. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/BasicPrinciplesTreatmentOfPrisoners.aspx>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

WMA (2019). *WMA Statement on Solitary Confinement*. World Medical Association, October 2019. Available at: https://www.wma.net/policies-post/wma-statement-on-solitary-confinement/#.XcpPquAh_Mk.email

4.6. Use of body searches

Body searches may constitute a necessary security measure in places of detention, to prevent the entry of dangerous goods (such as weapons), drugs, or other prohibited items (such as cell phones). They could be done in three different ways:

1. Pat-down or frisk searches, which refer to searches performed over a clothed body;
2. Strip searches, which refer to searches after the removal of some or all of a prisoner's clothing, in order to permit a visual inspection of all parts of the body, without physical contact;
3. Body-cavity (or invasive or intimate) searches, which refer to physical examinations of body cavities (such as the vagina or anus).¹⁷⁹

Body searches are mostly performed on prisoners, but could also be performed on the prisoners' visitors, including professional visitors such as social workers, and on prison (health) staff members. They are usually performed at the time of a prisoner's admission, before and/or after visits, when ordering placement in an isolation cell, or after exercise or workshops. Sometimes, the security classification of a prisoner implicitly involves a certain search regime. For instance, a prisoner suspected of terrorism may be searched every time he/she leaves or enters his/her cell.

Since a body search may be quite invasive for the person undergoing it, it may have physical and psychological health consequences, which is especially the case with body-cavity searches.

Relevance to preventive monitoring

'We are strip searched after every visit. We are naked, told to bend over, touch our toes, spread our cheeks. If we've got our period, we have to take the tampon out in front of them. It's degrading and humiliating. When we do urines it's even worse, we piss in a bottle in front of them. If we can't or won't we lose visits for three weeks.' (Prisoner from Fairlea Prison, Australia).¹⁸⁰

Body searches represent a high-risk situation for abuse, ill-treatment or even torture, and may be misused to intimidate, harass, punish or discriminate. The psychological effect and the violation of the right to dignity can be exacerbated for prisoners from certain religious or cultural backgrounds as well as for particular vulnerable prisoners, such as those with a history of sexual abuse.

Penal Reform International has in 2015 together with the Association for the Prevention of Torture issued a document called *'Body searches. Addressing risk factors to prevent torture and ill-treatment'* as part of their Detention monitoring tool. This document provides a comprehensive overview of the different kinds of body searches, the international standards, the situations at risk for abuse, ill-treatment or torture as well as inspirational guidance as to the aspects which prison monitors could check. Some of the information in the document has been integrated in this chapter, but health monitors are encouraged to read the full document when conducting a monitoring visit with specific focus on body searches.

Due to their intrusive nature, all body searches can in principle be inhuman or degrading. The more intrusive the method, the stronger the feeling of humiliation, submission and defenselessness will be. Even where legitimate in principle, searches can constitute inhuman or degrading

¹⁷⁹ PRI (2015). *Body searches. Addressing risk factors to prevent torture and ill-treatment*. Penal Reform International and Association for the Prevention of Torture, 2015. Available at: <https://www.penalreform.org/wp-content/uploads/2016/01/factsheet-4-searches-2nd-v5.pdf>

¹⁸⁰ George A, *'Strip searches: sexual assault by the state'*, in *Without consent: confronting adult sexual violence*, Australian Institute of Criminology, 1993, p211.

treatment if they are conducted in a way that is humiliating or creates a feeling of harassment or inferiority.

Also visitors may experience body searches which are humiliating and create feelings of harassment or inferiority. Visitors may in such case even choose not to conduct visits to the prisoner anymore, which results in negative consequences for the prisoner.

The European Court of Human Rights has pronounced several judgments that have particularly focused on the most invasive form of body searches, where the person is fully undressed and, in some cases, also asked to squat for a visual inspection of genital and anal areas. The Court has confirmed that such examinations may be degrading if they are not based on an assessment of necessity.

An example of a case where the Court has found a breach of article 3 of the European Convention on Human Rights (*'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'*) is described below.

Valašinas v. Lithuania 24 July 2001. While serving a prison sentence for the theft, possession and sale of firearms, the applicant was ordered, following the visit of a relative, to strip naked in the presence of a woman prison officer, which he claimed had been done in order to humiliate him. He was then ordered to squat, and his sexual organs and the food he had received from the visitor were examined by guards who wore no gloves.

*The Court found that the way in which this particular search had been conducted showed a clear lack of respect for the applicant, and in effect diminished his human dignity. It concluded that it had constituted degrading treatment in breach of Article 3 (prohibition of inhuman or degrading treatment) of the Convention.*¹⁸¹

International standards and guidance

Several international standards address the use of body searches in places of detention, including the Mandela Rules, the WMA Statement on body searches of prisoners, and the European Prison Rules. These provisions underline the need for regulations governing searches, the exceptional nature of body searches, and the need for searches to respect the prisoner's dignity and to be carried out by trained staff of the same gender. They also recommend the development and use of alternative searching methods.

The Mandela Rules stress that *'searches shall be conducted in a manner that is respectful of the inherent human dignity and privacy of the individual being searched, as well as the principles of proportionality, legality and necessity'* (Rule 50) and that *'searches shall not be used to harass, intimidate or unnecessarily intrude upon a prisoner's privacy.'* (Rule 51). They should be undertaken only *'if absolutely necessary'* (Rule 52). The Mandela Rules also stress the importance of accountability and the need to keep records of searches as well as their reasons, the identities of those who conducted them, and the results (Rule 51).

The Mandela Rules as well as the Bangkok Rules state that searches should be carried out by a person of the same gender as the person being searched (Mandela Rule 81 (3) and Bangkok Rule 19).

In relation to the role of health professionals in conducting body searches, the Mandela Rules state that *'Body cavity searches shall be conducted only by qualified health-care professionals other*

¹⁸¹ ECHR (2020). *Factsheet – Detention conditions and treatment of prisoners*. European Court of Human Rights, May 2020. Available at: https://www.echr.coe.int/Documents/FS_Detention_conditions_ENG.pdf

than those primarily responsible for the care of the prisoner or, at a minimum, by staff appropriately trained by a medical professional in standard of hygiene, health and safety.' (Rule 52.2).

The involvement of health professionals in body-cavity searches is, however, a complex and debated issue. On one site, there may be a risk of injury if a body-cavity search is not performed by a person with relevant medical skills. On the other site, involvement of health professionals will affect the relationship between the prisoner and the health professional and may impact the trust the prisoner has in health professionals. The health professional will be seen as part of the security system and working in the interest of the detaining authorities instead of being independent and working in the interest of the prisoner.

In 1993, the World Medical Association adopted a Statement specifically on Body Searches of Prisoners.¹⁸² This Statement reiterates the overarching principles of the individual's privacy and dignity in relation to body searches. The Statement stresses the ethical dilemma of involvement of prison health professionals in such searches, outlined in 14 principles, including that *'physician participation in body cavity searches for purposes of law enforcement or public safety involves complex issues of patient rights, informed consent, physicians' fiduciary obligations (dual loyalty matters) and their responsibilities to contribute to public health. A request to conduct a body cavity search puts the physician in the untenable position of potentially violating the ethical standards of his/her profession. Physician participation should be in exceptional cases only.'*¹⁸³

Contrary to this, the European Prison Rules address the role of the prison health professional in body searches in Rule 54.7 and state that *'an intimate examination related to a search may be conducted by a medical practitioner only'*.

In conclusion, it may be argued that even a health professional with no treatment responsibility for the patient inmate, employed by the law enforcement agency, clarifying his/her position as different from somebody providing treatment and possibly ensuring informed consent from the inmate, would still run the risk of damaging the doctor-patient relationship in general and undermining confidence in health professionals. Therefore, it is not advisable for health professionals to engage in body cavity searches, as is stated by the World Medical Association.

In addition to prisoners, also visitors, and staff members on special occasions, may be body searched to prevent them from passing prohibited objects into the institution. The obligation to protect the security of the prison always has to be balanced against the right of visitors and staff to their personal privacy. The Mandela Rules state the following regarding this procedure: *'Searches and entry procedures for visitors shall not be degrading and shall be governed by principles at least as protective as those outlined in rules 50-52. Body cavity searches should be avoided and should not be applied to children.'* (Rule 60.2).

The institution should keep records on the use of any kind of body searches, to ensure accountability. The record should include at least the following information: ID and gender of the person searched; the date and time of the search; the nature of the search; the facility where it took place; ID and gender of those who did the search; the reason for doing the search; the information given to the person to be searched as to the reasons for and the nature of the search; the ID of the officer who took the decision to carry out the search; the results of the search; the level of cooperation by the person searched /use of necessary force. Ideally, the searched person

182 WMA (1993, rev. 2016). *Statement on body searches of prisoners*. World Medical Association, 2016. Available at: <https://www.wma.net/policies-post/wma-statement-on-body-searches-of-prisoners/>.

183 WMA (2016). *WMA Statement on Body Searches of Prisoners*. World Medical Association, 1993, revisions in 2005 and 2016. Available at: <https://www.wma.net/policies-post/wma-statement-on-body-searches-of-prisoners/>

should with his/her signature confirm that the above information entered into the register is correct.

Laws and strict policies and regulations should be in place in the institution, governing the use of body searches, in order to avoid abuse and inhuman or degrading treatment. They should specify when searches are allowed, based on the criteria of necessity, reasonableness and proportionality, and the principle of 'last resort' for body-cavity searches. Alternatives, for instance electronic scanning devices, should be applied wherever possible, as stressed in the international standards.

Monitoring methodology

Monitors have an important role in looking into how, when and for what reason body searches are being conducted and the rules and regulations in place in the institution. Body searches are an example of a measure that, while legitimate and justified under certain circumstances, can in fact amount to ill-treatment.

Through observation of procedures, examination of registers, interviews with prisoners, prison guards, prison health staff and management, the health monitor can assess whether body searches are used as legitimate and adequate security measures or give reason for concern at a systemic level.

When interviewing the management of the institution, the health monitor should ask about any existing guidelines/policy on body searches, for prisoners, visitors and others. The management could be asked to elaborate on the general procedures when conducting body searches and the involvement of different staff members in the institution. Also the existence of special guidelines/procedures for women, LGBTI and children could be investigated. The management could furthermore be asked whether alternatives to body searches exist (such as electronic scanning devices) and what happens in case someone refuses to be searched or files a complaint about a body search afterwards.

Interviews with prisoners could give the health monitor first-hand information on how a body search has been experienced. Prisoners could be asked about the general procedure when they underwent a body search (both upon arrival in the institution and at any later point during their stay in the institution), which type of body search they underwent, and how they felt about it.

Prison health staff could be asked about their involvement/role in conducting body searches. The health monitor could for instance ask how they deal with this task with regard to medical ethics and their professional independence and ask for the main challenges they face.

Interviews with prison guards should focus on their involvement/role in conducting body searches. Prison guards could for instance be asked about any challenges and possible negative incidents related to body searches conducted in the institution.

Observations would mainly involve inspection of the space/room where body searches are conducted, to see whether this ensures privacy for the person being searched.

When looking into documents, the health monitor could look for written instructions on how to conduct the different kinds of body searches. Registers should be checked to see whether there is a register on body searches and whether it contains all the necessary information (see above for a list of items).

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

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WMA (1993, rev. 2016). *Statement on body searches of prisoners*. World Medical Association, 2016. Available at: <https://www.wma.net/policies-post/wma-statement-on-body-searches-of-prisoners/>

4.7. Use of urine samples

In many places of detention staff conducts regular mandatory drug testing by taking urine samples from prisoners, with the main aim to detect and discourage the use of illicit substances in the institution. Also, urine testing is the most commonly used monitoring technique in substance use treatment programmes.

Prisoners who undergo drug/alcohol testing by means of a urine sample can be selected randomly or on purpose (on suspicion of substance use). Moreover, the testing can be mandatory or voluntary for prisoners to participate in. In many countries, a random sample of prisoners is tested regularly. Some prisoners who are suspected of illicit drug use may be tested more frequently. Prisoners who voluntarily participate in a substance use treatment programme may be required to do urine tests as part of that programme.

On its own, mandatory drug testing by means of a urine test cannot solve the problem of drugs within prisons, but it does contribute to the overall objective of reducing drug use when used as part of a wider and more comprehensive drug strategy.

Urine testing is the most technologically developed method for detecting drug use. It is relatively affordable, easy to use, can be done conveniently in the institution and is readily available, and is therefore a popular control and security measure used in places of detention.

A urine sample can show whether or not a person has used drugs during the past 1 to 7 days. Common drug types which are tested by means of urine testing are amphetamines, barbiturates, cocaine and its metabolites, codeine, methadone, morphine and other opiates, marijuana, and phencyclidine. Besides testing for the use of illicit drugs, urine samples can be used for testing the use of alcohol. The period during which alcohol can be detected in urine depends on the type of test that is being used, varying from 2 till 12 hours after consumption (Ethanol urine test) to 8 till 80 hours after consumption (EtG urine test).¹⁸⁴ However, a breath or blood test may be more reliable to use for the detection of alcohol use.

Urine test kits do not have a perfect validity and reliability. For instance, false positives can occur when a person has not taken an illicit drug but has eaten food containing a legal amount of hemp, coca, or opium. Therefore, the practice of sending test results with positive results for confirmation at laboratories may be an important component of the safeguarding of prisoners.

Prisoners may attempt to manipulate test results, for instance by drinking lots of water just before the urine test is being taken (if they know about it coming), diluting the urine with tap water, adding substances to the urine that will interfere with the test results, or using other prisoner's urine if there is no direct observation when the test is taken.

Relevance to preventive monitoring

Requesting a urine sample from a prisoner must always be done with respect for the person's dignity and right to privacy. Authorities could misuse their power and control, for instance by asking prisoners to give a urine sample immediately and with the supervision of several staff members or asking for such a sample more often than needed. The circumstances under which a prisoner has to deliver a urine sample can in some cases amount to ill-treatment.

When a prisoner refuses to give a urine sample, this often leads to the same punishment as if he/she would have tested positive for drugs. Seldomly, prisoners do not refuse a sample as such, but are just not capable of delivering a urine sample upon request. For example, a prisoner

184 See: <https://www.therecoveryvillage.com/alcohol-abuse/faq/how-long-does-alcohol-stay-in-your-system/#gref>

may be taking medications that make urination difficult, or suffer from 'Shy Bladder Syndrome', a psychological condition in which individuals have trouble urinating in the presence of other people.¹⁸⁵

Below follows a case example brought for the European Court of Human Rights, demonstrating the dilemmas that arise when a prisoner is not capable of delivering a urine sample:

*Young v. United Kingdom. The applicant, who suffers from cerebral palsy, was sentenced to six months' imprisonment in 1999. The physical consequences of her condition include an inability to walk more than a few steps, leaving her largely confined to a wheelchair, and lack of control over her bladder. In addition, her ability to process information is diminished. In January 2000, the applicant was requested to provide a urine sample immediately to the prison authorities for the purpose of mandatory drug testing. She indicated that she was unable to comply with the request straightaway. She declined the offer of a cup of water since the difficulty lay not in the volume of urine she could produce but in the lack of motor control over her bladder. She was taken to her cell and a female prison officer waited there with her for the sample. When none was forthcoming, the prison officer indicated that this would be treated as a refusal and could result in additional days of detention. It is not clear whether the applicant explained to the prison officers the reason for her failure to provide a urine sample. Although the prison service was aware of her condition, the applicant did not volunteer information regarding her lack of bladder control, being too embarrassed to do so. Her embarrassment was compounded by the fact that, on that day, she was menstruating. In the days that followed, the applicant was brought before the prison governor on two occasions. He found that she had disobeyed a lawful order and sentenced her to 14 days' additional detention. She indicates that the governor did not consider her disability. The applicant then made her case more fully in writing, explaining her physical difficulties and indicating her distress at having her bodily functions discussed publicly. The governor reduced the sanction to three days' additional detention. The applicant's lawyers made representations on her behalf to the prison area manager, who responded that he considered the governor's decision was correct and that due allowance had been made for the applicant's disability by reducing the sentence. The applicant's release date was accordingly deferred by three days to Friday 26 January 2000. However, due to internal administrative reasons, she was not in fact released until the following Monday morning.*¹⁸⁶

International standards and guidance

None of the international standards as referred to in this manual, including the Mandela Rules, the Bangkok Rules and the CPT Standards, include any specific reference to the issue of urine testing.

Some countries may have national acts and/or guidelines on how to conduct urine sampling and analyze the results in places of detention. For instance, the UK has a Prison Service Order on Mandatory Drug Testing.¹⁸⁷ Also, the Sentence Enforcement Act in Denmark includes a require-

185 See for instance the Prison Service Order on Mandatory Drug Testing by the Prison Service in the UK, Para 6.63, 6.64. Available for download at: <https://www.justice.gov.uk/offenders/psos>

186 European Court of Human Rights. *Information Note No 48 on the case-law of the Court December 2002*. Young v. United Kingdom. Application No. 60682/00. Included in 'Humanity in Prison. Questions of definition and audit' by Andrew Coyle, International Center for Prison Studies. Available at: https://www.prisonstudies.org/sites/default/files/resources/downloads/humanity_in_prison.pdf

187 HM Prison Service (2007). *Prison Service Order on Mandatory Drug Testing*. Available for download at: <https://www.justice.gov.uk/offenders/psos>

ment that urine sampling is only to be conducted and observed by persons of the same gender as the prisoner.¹⁸⁸

In some systems, urine must be collected at a reasonable time of the day and by means of a plastic cup or collection kit provided by a specified laboratory. Often the sample is to be obtained under supervision of prison staff. Prison health professionals should never be involved in carrying out urine tests with the purpose of detecting illicit drug or alcohol use for non-medical purposes. They should only be involved in urine testing on medical grounds and with the informed consent of the patient.

If a prisoner is not able to give a urine sample, he/she should be allowed a reasonable time period (for instance max. 3 hours) to still do so. If a prisoner refuses or is not able to give a urine sample - when given a reasonable time period - this often leads to the prisoner being charged with a drug offence and/or being punished.

It is important that an institution keeps a register on the use of urine samples for drug testing. This register should include at least the following information: ID and gender of the person being tested, date and time for ordering the urine sample; reasons for doing so; ID of the person who ordered it and of those who were present during the sampling; the place where the sampling took place; the level of cooperation from the person tested; the result of the test. Ideally, the person examined should confirm with his/her signature that the information entered into the register is correct.

Monitoring methodology

When monitoring the way in which the institution deals with urine tests for detecting illicit drug and/or alcohol use, the health monitor should use all sources of information available to him/her.

When interviewing the management of the institution, the health monitor should focus on the general policy and procedures with regard to urine testing. He/she could for instance ask the management whether there are any internal guidelines on urine testing in the institution. Management could also be asked about the consequences for a prisoner who has given a positive test and for a prisoner who refuses or is not able to deliver a sample.

Interviews with prisoners could give information on how the tests are being performed and whether this is done with respect for their dignity. Questions could for instance include where and how the tests are performed, what happens when you are not able to give a urine sample, and what happens when the test gives a positive result.

Interviews with prison health staff should focus on their role in the use of urine tests for detecting the use of illicit substances. For instance, are they involved in the urine sampling or in the interpretation of the test results?

Prison guards are likely to be able to inform the health monitor about the procedure of urine testing, as they are most likely to be closely involved. The health monitor could for instance ask prison guards about the main challenges related to urine testing and of any negative incidences that may have happened over the last years.

¹⁸⁸ Folketingets Ombudsmand (2016). *Thematic report 2016 on body searching and urine sampling*. Folketingets Ombudsmand, Denmark, 2016. Available at: https://en.ombudsmanden.dk/publications/thematic_reports/thematic_report_2016_on_body_searching_and_urine_sampling/

The health monitor should use his/her observational skills to look at the space/room/sanitary facility where the urine tests are being performed and if this ensures prisoner's privacy and dignity.

Finally, the health monitor should look into any available documents with regard to urine tests. These include for instance any existing guidelines on how to conduct urine tests, the interpretation of their results and the consequences for the prisoner of a positive test. The monitor should also check whether the institution holds a register on the use of urine samples for drug testing and whether these include the required information as specified above.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

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4.8. Use of force

Police and prison staff may resort to the use of force to compel compliance by an unwilling detainee. In this chapter, the use of force only refers to the use of force by police and prison staff, and not by prisoners, visitors or others. Use of force by prisoners is referred to as violence and dealt with in the respective chapter in Section 5.

The use of force includes a wide range of different methods and techniques, which could be categorized in line with the use of force continuum. The use of force continuum is a standard/model that provides law enforcement officers and civilians with guidelines as to how much force may be used against a resisting subject in a given situation. The use of force continuum comes in many different forms. An example is the continuum outlined by the National Institute of Justice in the USA, as presented in box 9.

BOX 9. THE USE-OF-FORCE CONTINUUM

Officer Presence — No force is used. Considered the best way to resolve a situation.

Verbalization — Force is not-physical.

Empty-Hand Control — Officers use bodily force to gain control of a situation.

Less-Lethal Methods — Officers use less-lethal technologies to gain control of a situation

Lethal Force — Officers use lethal weapons to gain control of a situation. Should only be used if a suspect poses a serious threat to the officer or another individual.

Reference: The use-of-force continuum. National Institute of Justice.

Available at: <https://nij.ojp.gov/topics/articles/use-force-continuum>

This chapter focuses on the use of physical force only, as mentioned in the last three levels of use of force in the presented continuum, i.e.:

- Empty-hand control, which is used to describe the use of physical force without the use of non-lethal or lethal weapons.
- Less-lethal methods, which is used to describe the use of non-lethal weapons, such as pepper spray, truncheons, non-lethal ammunition weapons (rubber balls) or electrical discharge weapons.
- Lethal force, which is used to describe the use of lethal weapons, such as guns or rifles.

The use of physical restraint instruments is not explicitly referred to in the continuum but could be regarded as the use of less-lethal methods. The use of physical restraint instruments is dealt with in the following chapter in this Section.

The use of force in places of detention should always be kept to a minimum and only be used in exceptional situations when all other means are unhelpful, i.e. force should always be used only as a last resort. Exceptional situations in which the use of physical force may be legitimate, could be classified into the following three situations:

- As a legitimate defense, when there is an immediate threat of physical violence to a member of the prison staff, a co-detainee or a third party;

- As a way to stop an attempted escape;
- As a way of controlling a detainee refusing to comply with a lawful order.¹⁸⁹

Punishing a prisoner is never a legitimate reason for the use of force.

Relevance to preventive monitoring

The use of physical force may lead to several physical and psychological health consequences for the person experiencing it, and in most serious cases death. The use of physical force may constitute ill-treatment or even torture.

The European Court of Human Rights has received several complaints relating to the use of physical force by police and prison staff. The below is an example of a case where the Court has found a breach of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*).

Milić and Nikezić v. Montenegro. 28 April 2015

The applicants complained that they had been ill-treated by prison guards – they submitted that the latter had beaten them with rubber batons during a search of their cell – and that the ensuing investigation into their complaints had been ineffective. According to the Montenegrin Government, the guards had had to use force against the applicants to overcome their resistance on entering their cell.

The Court held that there had been two violations of Article 3 (prohibition of inhuman or degrading treatment) of the Convention, on account of the ill-treatment to which both applicants had been subjected during a search of their cell as well as the ineffectiveness of the ensuing investigation into their complaints of ill-treatment. The Court found in particular that, even though it had been established in the compensation and disciplinary proceedings concerning the applicants' complaint of ill-treatment that the guards had used excessive force, the damages awarded to the applicants had not been sufficient. Nor had the domestic courts or the Montenegrin Government actually acknowledged that such behaviour had amounted to ill-treatment. The Court on the other hand found that hitting the applicants with batons – as established by the domestic bodies – had amounted to ill-treatment within the meaning of Article 3.¹⁹⁰

International standards and guidance

There are several international standards and guidance documents addressing the use of (physical) force by detaining authorities.

The Mandela Rules 36-46 address 'restrictions, discipline and sanctions'. Although not explicitly referring to the use of force, Rule 38.1 does state that *'prison administrations are encouraged to use, to the extent possible, conflict prevention, mediation or any other alternative dispute resolution mechanism to prevent disciplinary offences or to resolve conflicts'*, which indirectly addresses the use of force and how this should be avoided as much as possible.

In 1990, the United Nations adopted the 'Basic Principles on the Use of Force and Firearms by Law Enforcement Officials'.¹⁹¹ The Principles state that use of force should always be seen as

189 APT. Website *Detention focus: Use of force*. Association for the Prevention of Torture. Available at: https://www.apr.ch/detention-focus/en/detention_issues/34/?vg=-1

190 ECHR (2020). *Factsheet – Detention conditions and treatment of prisoners*. European Court of Human Rights, May 2020. Available at: https://www.echr.coe.int/Documents/FS_Detention_conditions_ENG.pdf

191 UN (1990). *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*. Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, Cuba, 27 August to 7 September 1990. Available at: https://www.policinglaw.info/assets/downloads/1990_Basic_Principles_on_the_Use_of_Force_and_Firearms.pdf

a last resort and that in general ‘law enforcement officials, in their relations with persons in custody or detention, shall not use force, except when strictly necessary for the maintenance of security and order within the institution, or when personal safety is threatened’. It states in provision 5 that ‘whenever the lawful use of force and firearms is unavoidable, law enforcement officials shall:

- a. Exercise restraint in such use and act in proportion to the seriousness of the offence and the legitimate objective to be achieved;
- b. Minimize damage and injury, and respect and preserve human life;
- c. Ensure that assistance and medical aid are rendered to any injured or affected persons at the earliest possible moment;
- d. Ensure that relatives or close friends of the injured or affected person are notified at the earliest possible moment.’

The Principles also stress that ‘governments and law enforcement agencies shall establish effective reporting and review procedures for all incidents’.

Standard 53 of the CPT standards refers explicitly to the use of force and elaborates on the role of the medical doctor in this regard. It states that ‘A prisoner against whom any means of force have been used should have the right to be immediately examined and, if necessary, treated by a medical doctor. This examination should be conducted out of the hearing and preferably out of the sight of non-medical staff, and the results of the examination (including any relevant statements by the prisoner and the doctor’s conclusions) should be formally recorded and made available to the prisoner....’

Based on the international standards, the use of force by prison or police officials needs to adhere to the following international human rights principles:

- **The principle of legality.** The conditions for the use of force and methods used must be provided for in law and meet the norms of international law.
- **The principle of necessity.** The use of force must only be possible when strictly necessary.
- **The principle of proportionality.** The use of force must always be proportionate to the threat and not be handled in an arbitrary manner.
- **The principle of non-discrimination.** The principle of non-discrimination must also be built in the assessment of necessity and proportionality of the use of force to avoid that excessive or arbitrary force is used against a person out of prejudice or with discriminatory intent.
- **The principle of precaution.** Law enforcement actors at all levels should take precautions to avoid or minimize the use of force, that is, make a conscious effort—prior to the escalation of events—to minimize to the greatest extent possible the likelihood of using force
- **The principle of accountability.** Law enforcement agencies must be held accountable for the fulfilment of their duties and their compliance with the legal and operational framework with regard to the use of force.^{192 193 194}

The type of force used must always depend on the situation and the prison staff or other people responsible for the maintenance of order must be trained to adapt the type of force on a case by

192 Special Rapporteur on extrajudicial executions, UN Doc. A/HRC/26/36 (2014). Available at: <https://www.refworld.org/docid/53981a550.html>

193 UN (2017). *Resource book on the use of force and firearms in law enforcement*. Office of the United Nations High Commissioner for Human Rights and United Nations Office on Drugs and Crime, 2017. Available at: <https://www.ohchr.org/Documents/ProfessionalInterest/UseOfForceAndFirearms.pdf>

194 AI (2016). *Use of force. Guidelines for implementation of the UN Basic Principles on the use of force and firearms by law enforcement officials*. Amnesty International, 2016. Available at: https://www.amnesty.nl/content/uploads/2017/01/ainl_guidelines_use_of_force_short_version_0.pdf?x92184

case basis. For instance, lethal firearms should only be used when directly necessary to prevent loss of life.¹⁹⁵

The use of force needs to be strictly regulated and clear and transparent procedures need to be set. Because places of detention are closed communities in which abuse of authority could easily occur, there has to be a specific and transparent set of procedures for the use of force. There should be specific regulations covering the use of all methods of physical force. Staff members' access to physical restraint instruments, non-lethal and lethal weapons should be strictly regulated. Staff should not have unrestricted access to them and their use should be authorized by a senior staff member in advance. In some countries however, staff members are equipped with some kind of non-lethal or lethal weapon. In this case there should be very clear instructions available to them with regard to when they may be used.

A full record shall be made of any use of physical force by prison staff, the circumstances in which it was used, and the reason for it. Such records should be independently reviewed on a regular basis to ensure accountability.

Staff members need to be trained in techniques for controlling prisoners by methods using no or minimum physical force.¹⁹⁶

Monitoring methodology

The use of physical force in places of detention can amount to inhuman or degrading treatment or torture and is a very important area for a health monitor to look in to. The monitor should assess whether the use of force adhered to the principles of legality, necessity, proportionality, non-discrimination, precaution, and accountability.

When interviewing prison management, the monitor could for instance ask about the last few cases of excessive use of force and how this was dealt with and followed up on. Management could also be asked to explain which procedures for effective inspection and complaint procedures are in place and how they are applied.

Prisoners could give information about the use of physical force in the institution from their own experience. The monitor could ask if the prisoner has ever experienced the use of force by staff members in the institution and elaborate on the case and its follow-up. The monitor could ask whether the person got physically injured and was seen by a health professional.

Interviews with prison health staff will give the monitor information about their role in case of use of physical force in the institution. They could for instance be asked about the most recent cases of use of force in the institution and what their involvement was, during as well as after the events. They could also be asked whether they have ever used physical force on a prisoner, for non-medical or medical reasons.

Prison guards will often be the ones who have used physical force and are therefore an important source of information for the monitor. They could be asked about the most recent incidents and how these were dealt with/followed up on. Prison guards could also be asked whether they have received any training in the use of (physical) force and in conflict resolution techniques without the use of force.

195 Coyle & Fair (2018). *A Human Rights Approach to Prison Management. Handbook for prison staff. Third edition.* International Centre for Prison Studies, 2018. Available at: https://www.prisonstudies.org/sites/default/files/resources/downloads/handbook_3rd_ed_english_v5_web.pdf

196 Coyle & Fair (2018). *A Human Rights Approach to Prison Management. Handbook for prison staff. Third edition.* International Centre for Prison Studies, 2018. Available at: https://www.prisonstudies.org/sites/default/files/resources/downloads/handbook_3rd_ed_english_v5_web.pdf

Observations could give information about any physical restraint instruments, non-lethal weapons and lethal weapons present in the institution. The monitor could ask the prison staff to see the instruments and weapons available in the institution in order to assess their state.

An important information source in monitoring the use of force in an institution is looking into documentation, as the institution should have instructions/guidelines on the use of force for prison staff and keep record on all incidents. The records should be assessed on completeness and should include the following information for each case of use of force:

- ID of the person involved
- Date and time of the incident
- ID of the person who used force
- The method used (i.e. restraints, non-lethal weapons, lethal weapons)
- The reason for the use of force
- ID of those who informed the director about the incident (and date and time)
- In case that the doctor was called, reason for doing so and time for the call
- Doctors' findings and recommendations
- ID of those who did the debriefing

The records should also be assessed on whether they have been independently reviewed. Medical records of prisoners who have been exposed to physical force by staff could be assessed to see whether anything has been noted in the record relating to the incident and its health consequences.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

Coyle & Fair (2018). *A Human Rights Approach to Prison Management. Handbook for prison staff. Third edition*. International Centre for Prison Studies, 2018. Available at: https://www.prisonstudies.org/sites/default/files/resources/downloads/handbook_3rd_ed_english_v5_web.pdf

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.ref-world.org/pdfid/4d7882092.pdf>

UN (1990). *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*. Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Havana, Cuba, 27 August to 7 September 1990. Available at: https://www.policinglaw.info/assets/downloads/1990_Basic_Principles_on_the_Use_of_Force_and_Firearms.pdf

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UNODC (2017). *Resource book on the use of force and firearms in law enforcement*. United Nations, New York, 2017. Available at: https://www.policinglaw.info/assets/downloads/UNODC_Use_Of_Force_and_Firearms_Resource_Book.pdf

4.9. Use of physical restraint instruments

In order to maintain order and security, prison authorities may resort to physical restraint instruments. Physical restraint instruments are instruments that intent to restrain or temporarily restrict the movement of a person. Examples of physical restraint instruments are handcuffs, straps, restraining beds and electro-shock devices.

Physical restraint instruments may primarily be used in the following situations:

- to prevent the risk of escape during transfers of detainees
- to prevent physical assaults on other detainees or staff members or on the security of buildings
- to prevent acts of self-harm.¹⁹⁷

They could be divided into the following main types:

1. 'low-technology' mechanical restraint instruments – such as ankle cuffs, anklets, hand- or leg-cuffs, fetters, waist bands, wristlets, plastic cuffs, wraps, belts, shackles, chains, (weight-ed) leg irons or leg cuffs, body cuffs, gang chains, finger- and thumb cuffs, soft/fabric restraints, straightjackets.
2. 'four/five/six-point' restraint instruments – such as restraint chairs, shackle boards and restraint beds, and isolation beds.
3. body-worn electric-shock restraint instruments – such as stun belts, sleeves or cuffs.^{198 199}

Manually restraining a person without the use of instruments is not dealt with in this chapter, but instead in the previous chapter on the use of force in this Section.

Physically restraining a person may cause physical or psychological trauma, even when lesser restrictive methods are used. For example, the use of handcuffs may be painful and cause injuries to the wrists if it is prolonged or if the handcuffs are too tight.

Examples of dangerous health consequences which may result from the use of physical restraint instruments for longer periods of time, include:

- Deep venous thrombosis
- Unintended strangulation
- Cutting off blood circulation by restraints
- Nerve damage by restraints
- Cutting of blood vessels by struggling against restraints
- Excited delirium syndrome²⁰⁰
- Positional asphyxia²⁰¹

197 APT. *Website Detention focus: Means of restraint*. Association for the Prevention of Torture. Available at: https://www.apr.ch/detention-focus/en/detention_issues/35/

198 Electro-shock belts, sleeves or cuffs are instruments that encircle part of the person's body and deliver an electric shock when a remote control is being activated.

199 PRI/APT (2015). *Factsheet: Instruments of restraint. Addressing risk factors to prevent torture and ill-treatment, 2nd edition*. Penal Reform International & Association for the Prevention of Torture, 2015. Available at: https://www.apr.ch/content/files_res/factsheet-5_use-of-restraints-en.pdf

200 Strote et al. (2014). Medical conditions and restraint in patients experiencing excited delirium. *Am J Emerg Med*. 2014 Sep;32(9):1093-6. Doi: 10.1016/j.ajem.2014.05.023. Abstract available at: <https://www.ncbi.nlm.nih.gov/pubmed/24969437>

201 For example, by tying a person down flat on their back on the ground or applying the Total Appendage Restraint Procedure (TARP), consisting of simultaneously securing all of a person's arms and legs.

Determining the cause of death when a restrained person suddenly dies is often difficult. According to a report of 21 cases done by O'Halloran and Frank in 2000, a reasonable diagnosis of asphyxia due to restraint can usually only be made after ruling out other causes and collecting timely statements from witnesses and participants in the restraint procedure. Establishing a sequential association between the restraint and death is critical for making a correct determination of the cause of death.²⁰²

Relevance to preventive monitoring

Certain physical restraint instruments, such as chains and irons, are prohibited by international law. Others, such as body-worn electro-shock belts, sleeves or cuffs, have been more and more condemned, because of their humiliating and degrading effect. The UN Committee against Torture has recommended the abolition of electro-shock stun belts and restraint chairs and beds as methods of restraining prisoners, noting that their use almost invariably leads to breaches of Article 16 of the UN Convention against Torture.²⁰³ Also, the European Committee for the Prevention of Torture (CPT) opposes the use of electric stun belts, whether inside or outside places of detention, because the scope for misuse is very high and their use is inherently degrading.²⁰⁴

Besides the fact that the use of most physical restraint instruments is in itself humiliating and degrading for the person restrained, also the way in which they are used may be abusive. For example, even if the use of handcuffs is justified in a certain situation, they may be deliberately tightened in an excessive manner as a punishment. They may also be used discriminatorily, meaning that it particularly affects certain groups, regardless of their level of danger or their detention regime.

The European Court of Human Rights has received several complaints relating to the use of security measures, including the use of physical restraint instruments. The below is an example of a case where the Court has found a breach of article 3 of the European Convention on Human Rights ('No one shall be subjected to torture or to inhuman or degrading treatment or punishment').

Tali v. Estonia 13 February 2014. The case concerned a detainee's complaint about having been ill-treated by prison officers when he refused to comply with their orders. In particular, pepper spray was used against him and he was strapped to a restraint bed.

*The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention [...] As further regards the applicant's strapping to a restraint bed, the Court underlined in particular that measures of restraint were never to be used as a means of punishment of prisoners, but rather in order to avoid self-harm or serious danger to other individuals or to prison security. In the applicant's case it had not been convincingly shown that after the end of the confrontation with the prison officers – and being locked in a single-occupancy disciplinary cell – he had posed a threat to himself or others that would have justified applying such a measure. The period of three and a half hours for which he had been strapped to the restraint bed had therefore by no means been negligible and his prolonged immobilization had to have caused him distress and physical discomfort.*²⁰⁵

202 O'Halloran & Frank (2000). Asphyxial death during prone restraint revisited: A report of 21 cases. *American Journal of Forensic Medicine and Pathology* 21(1): 39-52. Abstract available at: <https://journals.lww.com/amjforensicmedicine/pages/articleviewer.aspx?year=2000&issue=03000&article=00007&type=abstract>

203 UN CAT (2000). *Concluding observations on United States of America*, A/55/44, May 2000, para. 180c. UN Committee against Torture, 2000. Available at: <http://hrlibrary.umn.edu/usdocs/torturecomments.html>

204 CPT, 20th General Report, p33; see also Council of Europe (2010) Press release: 'Council of Europe anti-torture committee calls for strict regulation of electrical discharge weapons', 26 October 2010. European Committee for the Prevention of Torture, 2010. Available at: <http://www.cpt.coe.int/en/annual/press/2010-10-26-eng.htm>

205 ECHR (2020). *Factsheet – Detention conditions and treatment of prisoners*. European Court of Human Rights, May 2020. Available at: https://www.echr.coe.int/Documents/FS_Detention_conditions_ENG.pdf

In worst case, instruments of restraint are directly and purposefully used as a torture tool, or to immobilize prisoners who are then beaten or otherwise abused.

International standards and guidance

The international standards and guidelines are clear: physical restraint instruments are to be used restrictively, only in exceptional cases, where other methods have been exhausted and failed.

Both the Mandela Rules and the European Prison Rules state that the use of restraint instruments that are *'inherently degrading or painful'*, including chains and irons, is not justified under any circumstances. Other restraint instruments shall only be used when authorized by law, for instance as a precaution against escape during transfer, or to prevent prisoners from injuring themselves or the building. In the latter case, the director of the institution *'shall immediately alert the physician or other qualified health-care professionals and report to the higher administrative authority'* (Mandela Rule 47).

Physical restraint instruments shall be as least intrusive as possible and shall be imposed only for the time period required and are to be removed as soon as possible after the risks posed by unrestricted movement are no longer present (Mandela Rule 48). Rule 48 also specifically outlines that *'instruments of restraint shall never be used on women during labour, during childbirth and immediately after childbirth'*, which is also addressed in Rule 24 of the Bangkok Rules. The United Nations Rules for the Protection of Juveniles Deprived of their Liberty stress that physical restraint instruments on juveniles may only be used in exceptional circumstances, only *'where all other control methods have been exhausted and failed, and only as explicitly authorized and specified by law and regulation'*.²⁰⁶

Training on the proper use of physical restraint instruments is of utmost importance. The Mandela Rules outline in Rule 49 that *'the prison administration should seek access to, and provide training in the use of control techniques that would obviate the need for the imposition of instruments of restraint or reduce their intrusiveness.'* The importance of training on the use of physical restraints has also been stressed by the UN Committee against Torture.²⁰⁷

The role of health professionals in the use of physical restraint instruments is guided – and limited – by the international standards. The Mandela Rules outline in Rule 46 that *'health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures'* and that *'health-care personnel shall report to the prison director, without delay, any adverse effect of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons.'*

Standard 53 of the CPT Standards elaborates on the role of the medical doctor when physical restraint instruments are being used and states that *'...when resort to instruments of physical restraint is required, the prisoner concerned should be kept under constant and adequate supervision.'*

Standards developed on medical ethics also prohibit health professionals from participating in procedures to physically restrain a prisoner for non-medical reasons. The UN 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

206 UN (1990). *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*. United Nations, 1990. Available at: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/JuvenilesDeprivedOfLiberty.aspx>

207 UN Committee against Torture: *Concluding observations on Germany*, 12 December 2011, CAT/C/DEU/CO/5, para. 16. Available at: <https://www.refworld.org/publisher,CAT,,DEU,4ef086d42,0.html>

Punishment state explicitly in Principle 5 that: *'it is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.'*²⁰⁸

The Physicians for Human Rights in their Guidelines for Prison, Detention and Other Custodial Settings reiterate that: *'the health professional should not perform any medical duties on shackled or blindfolded patients, inside or outside the custodial setting. The only exception should be in circumstances where, in the health professional's judgment, some form of restraint is necessary for the safety of the individual, the health professional and/or others, and treatment cannot be delayed until a time when the individual no longer poses a danger. In such circumstances, the health professional may allow the minimum restraint necessary to ensure safety.'*²⁰⁹

With regard to prevention of self-harm and suicide in prisons, the World Health Organization (WHO) states that:

*'Suicidal inmates may require protective clothing or restraints', but that 'because of the controversial nature of restraints, clear policies and procedures must be in place if they are to be used. These must outline the situations in which restraints are appropriate and inappropriate, methods for ensuring that the least restrictive alternatives are used first, safety issues, time limits for use of restraints, the need for monitoring and supervision while in restraints, and access to mental health staff'. The WHO further recommends the 'provision of social support' and 'routine visual checks and constant observation for acutely suicidal inmates' as alternatives.*²¹⁰

The doctor does, however, have an important role in checking and following-up on the physical and psychological effects of any instruments of restraint used. Generally speaking, the more incapacitating the method used, the more the person subjected to it is in a state of physical and psychological vulnerability, and the more crucial the role of the doctor.

The role of the health professional in a place of detention is always a difficult one when it comes to physical restraint instruments, knowing that they can have serious detrimental effects on a person's health. It is not always possible to assess whether a person may experience negative health effects because of being physically restrained and the health professional should therefore always aim to minimize negative impacts on the health of the person, which could include ensuring that the authorities are adhering to law and regulations. Not recommending the discontinuation of restraining a person may in fact imply indirect endorsement of the measure, which constitutes a difficult dilemma for the health professional (see also the chapter on the role of the prison health professional and dual obligation dilemmas in Section 3).

Medical monitoring is especially necessary in the case of prolonged use of a restraint method and the doctor must have the power to ask for the immediate suspension of the measure. Medical monitoring would entail at least:

208 UN (1982). *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations General Assembly, 1982. Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/MedicalEthics.aspx>

209 PHR. *Dual Loyalty and Human Rights. Guidelines for Prison, Detention and Other Custodial Settings*. Physicians for Human Rights, Boston, USA. Available at: <http://www.webcitation.org/getfile?fileid=cef65358623519e1a0cec3a-010408caf62b99469>

210 WHO/IASP (2007). *Preventing suicide in jails and prisons*. World Health Organization/International Association for Suicide Prevention 2007. Available at: https://apps.who.int/iris/bitstream/handle/10665/43678/9789241595506_eng.pdf?sequence=1&isAllowed=y

- Checking for risks of venous thrombosis (taking the individual risk factors of the restrained prisoners into consideration).
- Checking for acute needs of physical care
- Checking for acute needs of psychological care
- Checking for any signs of ill-treatment
- Checking whether prescription medicines have been given as prescribed

When the instruments of restraint have been removed, the people who have been subjected to them must have access to a doctor who needs to assess any possible consequences and whether any treatment needs to be given.

Staff members need training in how to restrain violent persons, if strictly necessary, without putting the lives and health of these persons at risk. Also, physical restraint instruments may never be used on a discriminatory basis, and vulnerabilities need to be taken into account regardless of the existence of explicit standards, for example regarding pregnant women, sick or injured persons, persons with disabilities, minority groups or indigenous peoples.

The Association for the Prevention of Torture and Penal Reform International have in 2015 issued a document called 'Instruments of restraint. Addressing risk factors to prevent torture and ill-treatment' as part of their Detention monitoring tool. This document provides a comprehensive overview of risks deriving from the use of instruments of restraints in the penitentiary context.²¹¹

Monitoring methodology

The use of physical restraint instruments and the way in which they are used can amount to inhuman or degrading treatment or torture and is a very important area for a health monitor to look in to. The misuse of physical restraint instruments has resulted in many injuries and in some cases death.

Monitors should assess the circumstances of the use of restraint instruments and any specific safeguards in place against abuse. They should establish whether physical restraint instruments prohibited under international law are excluded, whether the use of restraints is applied consistently with the principles of necessity and proportionality rather than on a routine basis, and whether the role of the health professional in the institution is clearly explained.

When interviewing the prison management, the monitor should ask whether and which regulations and procedures are in place with regard to the use of physical restraint instruments and whether there are specific safeguards against abuse. Prison management could also be asked whether physical restraint instruments that are prohibited under international law, are explicitly forbidden in the institution.

Interviews with prisoners could give the monitor information on whether and how physical restraint instruments have been used during several procedures (for instance, handcuffs upon entry?), whether they are applied routinely or on an individual basis (discriminatory against certain prisoners or groups of prisoners?) and how their use has been experienced.

Prison health staff could be asked whether they have any role in the use of physical restraint instruments. They could be asked to provide examples and the monitor could review the records

211 PRI/APT (2015). *Factsheet: Instruments of restraint. Addressing risk factors to prevent torture and ill-treatment, 2nd edition*. Penal Reform International & Association for the Prevention of Torture, 2015. Available at: https://www.apr.ch/content/files_res/factsheet-5_use-of-restraints-en.pdf

made. Prison health staff could also give information on whether prisoners have access to medical care following the use of restraint instruments in order to check for any adverse health consequences.

The monitor could ask prison guards about the procedures and practices with regard to the use of physical restraint instruments in the institution. They could also be asked whether they have had any training in the use of these instruments and what the training included.

Observations would include looking for any physical restraint instruments available in the institution and how they look in terms of functionality, safety and decency. In case a prisoner is subjected to physical restraint during the monitoring visit, this should also be observed.

Finally, the monitor could check the documents to assess the use of physical restraint instruments in the institution. These include records on their use, medical files of prisoners (anything noted in those?) and any written instructions that may exist.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

APT. *Webpage Detention Focus: Means of restraint*. Association for the Prevention of Torture. Available at: https://www.apr.ch/detention-focus/en/detention_issues/35/

CoE (2006). *European Prison Rules*. Council of Europe, Strasbourg, 2006. Available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the prevention of torture and inhuman or degrading treatment or punishment, 2010. Available at: <https://www.ref-world.org/pdfid/4d7882092.pdf>

PRI/APT (2015a). *Balancing security and dignity in prison: a framework for preventive monitoring, 2nd edition*. Penal Reform International & Association for the Prevention of Torture, 2015. Available at: <https://www.penalreform.org/wp-content/uploads/2016/01/security-dignity-2nd-ed-v6.pdf>

PRI/APT (2015b). *Factsheet: Instruments of restraint. Addressing risk factors to prevent torture and ill-treatment, 2nd edition*. Penal Reform International & Association for the Prevention of Torture, 2015. Available at: https://www.apr.ch/content/files_res/factsheet-5_use-of-restraints-en.pdf

UN (2010). *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)*. United Nations General Assembly, New York, December 2010. Available at: <https://cdn.penalreform.org/wp-content/uploads/2016/07/BangkokRules-Updated-2016-with-renumbering-SMR.pdf>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

4.10. Safety and security

'Secure prisons are essential to making our justice system an effective weapon against crime. When prisoners – convicted or awaiting trial – are entrusted to your care, they must know and the public must know that they will remain there until they are legally discharged' - President Nelson Mandela in his speech to prison staff in South Africa, 1998.²¹²

Safety and security are terms that automatically come to mind when thinking about places of detention. A major objective of places of detention is to prevent prisoners from escaping and thus protecting the population against them, as well as to ensure the safety and security of the prisoners, staff members and visitors in the institution, by protecting them against, for instance, fire, accidents, violence, disease and other harm and injury. Conditions of overcrowding and shortage of staff members clearly have an impact on the security and safety level in an institution. Moreover, feeling safe and secure can be very difficult when detained, because one's life situation is often far from safe and secure.

Safety and security are terms that are often used together, but in fact mean something different.

As outlined by ICRC, safety can be defined as freedom from risk or harm as a result of *unintentional events* (accidents, natural phenomena or illness), while security may be defined as freedom from risk or harm resulting from *violence or other intentional acts*.²¹³

Security could be further divided into three categories, i.e. *physical*, *procedural* and *dynamic* security.²¹⁴

Physical security, also referred to as static security, refers to the security of the infrastructure, which can work contributive or preventive to violence and other intentional acts.²¹⁵ Examples are a video surveillance system in the institution, or the alarm system. In designing the physical aspects of security, a balance needs to be found between the best way of achieving the required security level and the need to respect the dignity of the individual. In many countries, places of detention are divided into several security levels, for instance, low, medium and high security. The purpose of such division is to avoid that a minority of dangerous and violent criminals jeopardize the security of fellow prisoners and to prevent escape. In principle, prisoners should never be kept in security levels which are more restrictive than necessary.

Procedural security relates to those procedures which have to be followed to prevent escape and to maintain good order.²¹⁶ They are targeted and structured actions conducted by prison staff such as security checks, searches, controls and various routines. A procedure can be defined as a process that has been standardized as an approach expected to achieve regulation,

212 In his speech at the official launch of the re-training and human rights project of the South African Department of Correctional Services, Kroonstad, 25 June 1998.

213 ICRC (2015). *Ensuring the preparedness and security of health-care facilities in armed conflicts and other emergencies*. International Committee of the Red Cross, Geneva, 2015. Available at: <https://shop.icrc.org/des-structures-medicales-plus-sures-et-mieux-preparees-aux-conflits-armes-et-autres-situations-d-urgence-2322.html>

214 UNODC (2015). *Handbook on Dynamic Security and Prison Intelligence*. United Nations Office on Drugs and Crime, New York, 2015. Available at: https://www.unodc.org/documents/justice-and-prison-reform/UNODC_Handbook_on_Dynamic_Security_and_Prison_Intelligence.pdf

215 UNODC (2015). *Handbook on Dynamic Security and Prison Intelligence*. United Nations Office on Drugs and Crime, New York, 2015. Available at: https://www.unodc.org/documents/justice-and-prison-reform/UNODC_Handbook_on_Dynamic_Security_and_Prison_Intelligence.pdf

216 Coyle & Fair (2018). *A Human Rights Approach to Prison Management. Handbook for prison staff. Third edition*. International Centre for Prison Studies, 2018. Available at: https://www.prisonstudies.org/sites/default/files/resources/downloads/handbook_3rd_ed_english_v5_web.pdf

consistency and fairness and to assist prison managers and staff members to carry out their duties.²¹⁷

Physical and procedural security are not enough to ensure a secure prison environment and need to be looked at together with dynamic security. Dynamic security has been defined by the UN as *'actions that contribute to the development of professional and positive relationships between prison staff and prisoners as a specific approach to security that is based on knowledge of the prison population and an understanding of the relationships between prisoners and between prisoners and prison staff'*.²¹⁸ As outlined by UNODC, the concept of dynamic security includes:

- Developing positive relationships with prisoners
- Diverting prisoners' energy into constructive work and activity
- Providing a decent and balanced regime with individualized programmes for prisoners
- Establishing an adequate ratio of staff to prisoners²¹⁹

Safety and security are inherently linked to many aspects of detention, such as prison regimes, physical restraint measures, hygiene, food safety etc. Many safety and security issues have a direct or indirect impact on physical or psychological health and are also addressed in other chapters of this manual, including the chapters on physical restraint measures, use of solitary confinement, hygiene, and nutrition.

Safety and security should be sought as much as possible in all aspects of prison life, including in dormitories, yards, common facilities including bathing facilities, and at the prisoners' workplace. There have been plenty of examples of poor safety and security at workplaces. The safety and security in the prisoners' workplace should be of equivalent standard as safety and security in workplaces in the outside community.²²⁰

Relevance to preventive monitoring

Prison authorities need to make efforts to create a place as safe and secure as possible, in order to adhere to their obligation to protect all prisoners under their supervision and care. Not providing prisoners with a safe and secure environment may amount to ill-treatment and torture.

An example of a dynamic security issue would be 'weak prisoners' who are controlled by 'strong prisoners' to such a degree that they are threatened, abused and mistreated. When prison authorities and staff members are aware of this and do not undertake action to protect these prisoners, this would be classified as ill-treatment or torture.

217 UNODC (2015). Handbook on Dynamic Security and Prison Intelligence. United Nations Office on Drugs and Crime, New York, 2015. Available at: https://www.unodc.org/documents/justice-and-prison-reform/UNODC_Handbook_on_Dynamic_Security_and_Prison_Intelligence.pdf

218 UN (2013). Prison Incident Management Handbook. United Nations, 2013. Available at: https://www.un.org/ruleoflaw/files/Prison_Incident_Management_Handbook_OROLSI_Mar2013.pdf

219 UNODC (2013). Handbook for Prison Leaders. A basic training tool and curriculum for prison managers based on international standards and norms. United Nations Office on Drugs and Crime, 2010. Available at: https://www.unodc.org/documents/justice-and-prison-reform/UNODC_Handbook_for_Prison_Leaders.pdf

220 Montoya Barthelémy (2019). The Occupational Health of Prison Inmates: An Ignored Population and An Opportunity. *Journal of the American College of Occupational and Environmental Medicine*, Volume 61, Number 2, February 2019. Available at: https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-education-and-research-center-for-occupational-safety-and-health/2019_JOEM_The_Occupational_Health_of_Prison_Inmates.pdf

An example of lack of safety that may result in ill-treatment would be a fire in the institution due to electrical faults such as unsafe electrical wiring.²²¹ Another example would be a flooding, where prisoners are unable to leave the institution and relocate to a safe place.²²²

Also the security during transfers of prisoners between institutions must be guaranteed by the authorities. The European Court on Human Rights has received the following case relating to unsecure conditions during transfer, which the Court found to be a violation of article 3 of the European Convention on Human Rights (*'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'*)

Ilgiz Khalikov v. Russia 15 January 2019. This case concerned a prisoner's complaint that he had been seriously wounded by a stray bullet during a shoot-out between escorting officers and detainees attempting to escape during their transfer to another facility. The applicant also alleged that the authorities had failed to carry out an effective investigation into the incident which, he emphasised, had left him disabled for life and in considerable pain.

*The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention. It found in particular that the State had been responsible for the applicant's injury because the escorting officers had disregarded the regulations put in place for the security of detainees during transfers. In particular, the officers had decided to transport more detainees than the prison van had been designed to accommodate. The fact that the van had been over its capacity had meant that detainees had been able to attempt to overpower officers and that the applicant, a former police officer and therefore a vulnerable detainee who should have been travelling in a separate cell, had been in the rear of the van with two of the escorting officers when the attack had taken place. Furthermore, the investigation into the incident had been ineffective. The pre-investigation inquiry had been marred by delays, limited in scope and had never progressed to the stage of a criminal investigation.*²²³

International standards and guidance

International standards oblige States to protect all prisoners under their supervision and care, i.e. guaranteeing them a safe and secure environment and daily life.

The Mandela Rules outline in their first basic principle that *'...the safety and security of prisoners, staff, service providers and visitors shall be ensured at all times.'* The Rules also stress the importance of training prison staff on *'security and safety, including the concept of dynamic security, the use of force and instruments of restraint, and the management of violent offenders, with due consideration of preventive and defusing techniques, such as negotiation and mediation'* (Rule 76c).

Also the European Prison Rules stress the importance of safety and security in their Rules 51-53, including reference to dynamic security in Rule 51.2: *'The security which is provided by physical barriers and other technical means shall be complemented by the dynamic security provided by an alert staff who know the prisoners who are under their control.'*

Dynamic security includes the need that prison staff should actively and frequently observe and interact with prisoners to gain a better understanding and awareness of the prisoners' views and needs and the way their networks inside the prison work. It is a way of maintaining a dialogue

221 See for example: Prison fire in Morocco in 2002: <http://news.bbc.co.uk/2/hi/africa/2385145.stm>

222 See for example: Hurricane in the US in 2005: <https://www.aclu.org/press-releases/aclu-report-details-horrors-suffered-orleans-parish-prisoners-wake-hurricane-katrina>

223 ECHR (2020). *Factsheet – Detention conditions and treatment of prisoners*. European Court of Human Rights, May 2020. Available at: https://www.echr.coe.int/Documents/FS_Detention_conditions_ENG.pdf

between prisoners and staff members and a way of assessing and mitigating risks for the safety and security.

In some countries, prison authorities have lost control of their institution and have allowed (powerful groups of) prisoners to exert a system of control over other prisoners (and sometimes staff members as well).²²⁴ Its existence is unfortunate, but in most poor countries and in nearly all Latin American countries such a system exists and is accepted by the highest authorities as a way of coping with a very low number of staff members. However, authorities must be vigilant that the system is working in a “democratic” non-repressive (between prisoners) manner. Ideally, prisoners given some authority should be appointed jointly by fellow prisoners and management (intending to avoid that strong violent prisoners threaten fellow prisoners to appoint them). Also, prisoners should not be given any position of power - if they cannot solve a conflict through persuasion or mediation they must call staff members. They should be seen as mediators and messengers and organizers /administrators of trivial everyday duties (such as cleaning and maintaining order), rather than as authorities and must have clear instructions in what to do and how to do it. The rules governing their work must be known by all staff members and prisoners and they must be supervised by staff members. Fellow prisoners must have easy access to lodging complaints about them.

Also, in countries where prison authorities are in control and shortage of staff members is not an issue, systems of some prisoners having control over others exist. It is an expression of the jungle law and the difficulties that authorities have in keeping all aspects of prison life under control – particularly in places where many members of the same criminal gang are gathered. Such systems are in all aspects unacceptable. Situations where prisoners are in control over other prisoners are prone to threats, manipulation and bribery and as such a threat to the safety and security in the institution. Every service that should be free of charge may get a price, e.g. visit by the families, visit to the doctor, taking part in activities etc. Prison authorities may very well be aware and even supportive to such system.

A (partly black) market inside the prison exists in many countries, where items may be purchased, including drugs. There is often a system of discipline, alternative to the official one. Prisoners in opposition to this alternative system are threatened or punished and all prisoners know that revealing too many details to, for instance, external monitors may be dangerous. Sometimes great amounts of money are in play. Most of the profit will go to authorities (e.g. in the form of ‘rent for having a booth at the market place’). However, some prisoners earn so much money that they are able to pay authorities for being placed in ‘luxury’ cells. Monitors should look for great differences in prisoners’ living conditions and should enquire about the background for observed differences.

Vulnerable groups are often in need of additional protection measures in order to ensure their security in a place of detention. For instance, LGBTI, prisoners with HIV/AIDS and prisoners (who are suspects of) having committed certain types of crimes are at increased risk of stigmatization, discrimination and abuse by other prisoners and staff members, while foreign nationals will often not speak the common language in the institution which makes them at risk of, for instance, not understanding safety instructions.

224 See for instance the Special Edition of the Prison Service Journal on the Informal dynamics of survival in Latin American prisons, January 2017: <http://research.gold.ac.uk/20771/1/PSJ%20229%20January%202017.pdf>

Monitoring methodology

When assessing the safety and security in the institution, the health monitor should pay particular attention to the health consequences of different aspects of safety and security. These could for instance include:

- Prisoners having increased health risks due to poor safety measures, such as a building infrastructure conducive to accidents.
- Prisoners having increased health risks due to poor safety, such as mold on walls and polluted air. Poor ventilation system in the institution could for instance be contributing to the spread of airborne diseases.
- Prisoners being allocated to high security wards, restricting their ability to participate in activities and social contacts, having a detrimental impact on their mental health.

It is important for a monitor to keep in mind that monitoring places of detention may in itself have an impact on the security in an institution. The overall idea of monitoring places of detention is of course that the presence of monitors will eventually improve the safety and security of the prisoners, ensuring that their rights are respected. However, monitoring may be harmful for single prisoners and even result in severe harm being inflicted on a prisoner talking to a member of the monitoring team and therefore being considered a disloyal informant by staff or other prisoners. Therefore, monitoring places of detention always represents a dilemma between doing good for a large number of persons while risking doing harm to one or a few persons.

When visiting the institution, the health monitor should use all information sources available to him/her to monitor the safety and security in the institution.

The management of the institution could for instance be asked about the criteria for classifying the level of security needed for individual prisoners, about how safety and security are addressed in the institution's policies and procedures, and to elaborate on how any safety or security incident that may have happened in the institution during the last years was managed.

Interviews with prison health staff should focus on how they think that the safety and security measures in this institution may impact on prisoners' health and on whether there have been any incidents during the last years where prisoners' health was endangered due to poor safety or security.

Prisoners could be asked whether they feel safe and secure in the institution and what they see as the main risks. The monitor should also aim to interview prisoners in high security wards and prisoners belonging to a vulnerable group to learn their experiences with safety and security in the institution.

Prison guards could inform the monitor about the general safety and security, including procedural security and dynamic security, in daily life in the institution. They could elaborate on any incidents that may have happened over the last years and on how they were handled.

Observations should focus on physical and procedural security issues and whether they may impose a risk to prisoners. They should also focus on the interaction between staff members and prisoners to assess the dynamic security. Monitors should always aim to visit to the prisoners' workplaces, to assess the safety and security of those places.

Documents the monitor could look for include for instance written safety and security instructions for staff members and/or prisoners, and registers on any incidents.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CoE (2006). *European Prison Rules*. Council of Europe, Strasbourg, 2006. Available at: http://www.coe.int/t/dgi/criminallawcoop/Presentation/Documents/European-Prison-Rules_978-92-871-5982-3.pdf

ICRC (2015). *Ensuring the preparedness and security of health-care facilities in armed conflicts and other emergencies*. International Committee of the Red Cross. Available at: <https://shop.icrc.org/des-structures-medicales-plus-sures-et-mieux-preparees-aux-conflits-armes-et-autres-situations-d-urgence-2322.html>

UN (2013). *Prison Incident Management Handbook*. United Nations, 2013. Available at: https://www.un.org/ruleoflaw/files/Prison_Incident_Management_Handbook_OROLSI_Mar2013.pdf

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UNODC (2013). *Handbook for Prison Leaders. A basic training tool and curriculum for prison managers based on international standards and norms*. United Nations Office on Drugs and Crime, 2010. Available at: https://www.unodc.org/documents/justice-and-prison-reform/UNODC_Handbook_for_Prison_Leaders.pdf

UNODC (2015). *Handbook on Dynamic Security and Prison Intelligence*. United Nations Office on Drugs and Crime, New York, 2015. Available at: https://www.unodc.org/documents/justice-and-prison-reform/UNODC_Handbook_on_Dynamic_Security_and_Prison_Intelligence.pdf

SECTION 5: MONITORING PRISONERS' HEALTH

5.1. Introduction

The World Health Organization defines health as *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'*.²²⁵ This broad definition of health stresses that health is a wide-ranging concept and does not only mean that a person is free from illnesses and disabilities but is 'healthy' in a much broader understanding.

This section addresses several aspects of prisoners' health. Each of the following chapters addresses a specific health issue and focusses on:

- What is the scope of the health issue?
- How is it of relevance to preventive monitoring on torture and ill-treatment?
- What do international standards and guidance say and how to interpret them?
- How to monitor the health issue?

The right to health

The Constitution of the World Health Organization defines the right to health as *'the enjoyment of the highest attainable standard of health'* and states that *'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'*.²²⁶

In their factsheet on human rights and health, the WHO states that *'understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality'*.²²⁷

International bodies and standards have stressed the right to health for all human beings. The UN Committee on Economic, Social and Cultural Rights comments on the right to the highest attainable standard of health (as stated in the International Covenant on Economic, Social and Cultural Rights²²⁸) that *'health is a fundamental human right indispensable from the exercise of other rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity'*.²²⁹ The UN Convention on the Rights of a Child²³⁰ and the UN Convention on the Elimination of All Forms of Discrimination against Women²³¹ stress the right to health for children and adolescents, and for women respectively. Moreover, regional instru-

225 WHO (1948). *Constitution of the World Health Organization*. Geneva, 1948. Available at: <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

226 WHO (1948). *Constitution of the World Health Organization*. Geneva, 1948. Available at: <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

227 <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>

228 UN (1976). *International Covenant on Economic, Social and Cultural Rights*. United Nations, 1976. Available at: <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>

229 UN (2000). *The right to the highest attainable standard of health*. Committee on Economic, Social and Cultural rights, 22nd session, Geneva, 25 April – 12 May 2000, Agenda item 3. Available at: http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf

230 UN (1990). *Convention on the Rights of the Child*. UN High Commissioner for Human Rights, New York, 1990. Available at: <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

231 UN (1979). *Convention on the Elimination of All Forms of Discrimination against Women*. UN High Commissioner for Human Rights, New York, 1979. Available at: <https://www.ohchr.org/en/professionalinterest/pages/cedaw.aspx>

ments, including the American Declaration on the Rights and Duties of Man²³² and the African Charter on Human and Peoples' Rights²³³ stress the right to health for all human beings without discrimination.

Persons deprived of their liberty have the right to health to the same degree as any other human being and being imprisoned should not affect this right in any way. An article published by Lines in 2008 titled '*The right to health of prisoners in international human rights law*', gives a very comprehensive overview of all relevant standards addressing the right to health of prisoners.²³⁴ The Mandela Rules are a key instrument worth highlighting and in Rule 24 clearly states that '*the provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status*'.

Besides access to health care services, the right to health also embraces prison health factors such as physical environmental conditions like security, safety, safe food and drinking water, sufficient nutrition, clean air, adequate levels of sanitation, and access to physical activity.

General remarks on prisoner's health

In most countries, a vast majority of prisoners come from poor communities and vulnerable social groups in society. Often these groups have had very little access to health care before their imprisonment and on average have a poorer general health status than the general population at the time of admission.

Compared to the general population, prisoners have a higher prevalence of communicable diseases like HIV, TB and hepatitis C/B, higher risks of NCDs, oral health issues, as well as a broad range of mental health problems. Self-harming and suicide are more common in places of detention than in the community and a higher proportion of prisoners suffers from drug and/or alcohol dependencies compared to people living in the general community.

Conditions and (lack of) treatment in a place of detention can further deteriorate a prisoner's health. For instance, a lack of harm reduction measures available for people who use illicit drugs can facilitate the spread of HIV/AIDS and Hepatitis within the prison population by unsafe injecting practices and needle and syringe sharing.²³⁵ In general, overcrowding and close contact between infected and non-infected individuals facilitates transmission of diseases. When combined with poor standards of health care services, for instance lack of identification of open TB in a prisoner upon arrival in the institution, the risk of spread is many times increased compared to the risk in the general population. Moreover, non-communicable diseases seem to be ignored or given low priority in some prison settings. They can be assumed to be at least as prevalent in places of detention as in the outside communities (see for more details the chapter on Non-communicable diseases in this Section).

Ignoring prisoners' health conditions, lack of access to health care services and poor environmental conditions may harm prisoners' health and cause unnecessary suffering amounting to

232 IACHR (1948). *American Declaration on the Rights and Duties of Man*. Inter-American Commission on Human Rights, 1948. Available at: https://www.oas.org/dil/access_to_information_human_right_American_Declaration_of_the_Rights_and_Duties_of_Man.pdf

233 OAU (1986). *African Charter on Human and Peoples' Rights*. Organization of African Unity, 1986. Available at: http://www.achpr.org/files/instruments/achpr/banjul_charter.pdf

234 Lines R (2008). The right to health of prisoners in international human rights law. *International Journal of Prisoner Health*, March 2008; 4(1): 3-53. Available at: https://www.researchgate.net/publication/5469547_The_right_to_health_of_prisoners_in_international_human_rights_law

235 Fazel and Baillargeon (2011). The health of prisoners. *The Lancet* 2011; 377:956-65. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(10\)61053-7.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)61053-7.pdf)

inhuman and degrading treatment. This applies to any disease for which there exist treatment possibilities in the general community.

Monitoring prisoners' health

Monitoring prisoners' health aims to get insight in a number of issues, i.e.:

- The health issues prevailing in the place of detention and individual health problems. When a monitor identifies a health problem, for instance a disease ignored by the prison doctor or a case of ill-treatment, the case should 1. be assessed /evaluated as far as available information permits, which could lead to recommendations concerning the individual (with informed consent); and 2. lead to an analysis of the reasons why the problem occurred, e.g. insufficient staffing, equipment, training of staff members or instructions /guidelines/ supervision. This means that when a problem (e.g. deficient health service, ill-treatment) is identified, the analysis starts with an assessment of the individual case and then moves on to the general preventive aspects as to prison health services and prison health factors.
- The degree to which prison health authorities take their responsibility in ensuring the right to health for all. This should cover amongst other issues the quality of diagnosing, treatment and containment of spread of communicable diseases; prevention, identification and treatment of non-communicable diseases; as well as the handling of mental diseases. It is important to analyze the significance of prison health services' and prison health factors' role in the spread of communicable diseases and the development of non-communicable diseases and mental health conditions, as well as the prison health services' and the management's role in implementation and evaluation of disease prevention and health promotion initiatives.
- The right of prisoners to have access to health examinations and to be asked for informed consent before any treatment, equivalent to in the general society (i.e. equivalence of care, autonomy, and right to a decent life).
- Possible indicators for the occurrence of torture or ill-treatment in the monitored place of detention or in places of detention where the prisoners were kept before they were transferred to this place. Also, the institutional approach to detect and follow-up on such cases. The health service in the institution has a primary role in the identification of cases of torture and ill-treatment and in ensuring that cases are adequately examined, documented, treated and reported to the competent authorities for an impartial investigation.
- The collaboration between the prison health services and the health care services in the community, not only as to specialized treatment during imprisonment, but also as to continuity of care upon entry and after release of prisoners with diseases that need follow-up and medication, for instance those infected with TB or HIV, and those who suffer from NCDs or mental health diseases.
- The cases of deaths which occurred in custody and the circumstances leading to each death.

Monitoring methodology

Monitoring prisoners' health involves looking into a broad range of health issues and obtaining information on these from various information sources.

When monitoring prison health, it is important to know the local pattern of diseases, keeping in mind that the incidence and prevalence of diseases can vary considerably between the general community and prison settings.

Before the monitoring visit, the monitor should consider if there are any areas of health he/she finds particularly important or underexplored in previous visits. A health monitor should prepare him/herself for the visit by looking into any relevant documentation that can be accessed.

The below health monitoring matrix (figure 6) gives an overview of all aspects of prisoners' health which will be addressed in the following chapters and the sources of information which the monitor could consult while visiting the place of detention.

FIGURE 6.
HEALTH MONITORING MATRIX – PRISONERS' HEALTH

Aspects of prisoners' health	Sources							
	Prisoners	Health staff	Prison guards	Prison management	Observations	Documents		
						Medical records	Registers	Written instructions
Mental health problems								
Self-harming and suicide								
Non-communicable diseases								
Communicable diseases								
Substance use disorders								
Oral health								
Special needs								
Specific needs of female prisoners and accompanying children								
Violence								
Death in custody								

The matrix is a useful tool during any monitoring visit, where crosses could be placed at the information sources used or obtained information could be summarized. It is important to choose the right questions for the different groups of interlocutors. Some of the questions should be asked to different groups (and different documents should be investigated), in order to triangulate and get the most complete and reliable assessment of the situation.

Observations are essential for, inter alia, assessing visible signs of both physical and mental diseases among prisoners, including signs of torture and ill-treatment, and for assessing overall prison conditions. As already outlined in Section 2, the main task of the health monitor is NOT to conduct medical examinations of individual prisoners. The key task of the health monitor is to keep his/her eyes and ears open and observe anything that may be of interest for making up his/her assessment of the health in the institution, and to ask for more information on anything that he/she notices that needs further investigation. Observations can be made both when interviewing prisoners and when walking around in the premises.

Looking into documentation concerning prisoners' health includes foremost written instructions, registers and individual case reports (medical records). The monitor should be aware of his/her mandate to look into a prisoner's medical record and whether or not informed consent is always needed. Regardless of whether a prisoner's informed consent is needed to look into his/her medical record, informed consent is often needed when following-up on the findings in the record.

The next chapters describe in detail what to look into with regard to the different areas of health. It can be challenging though to explore every health area in one visit. It is therefore recommendable that the health monitor plans for a realistic and focused visit and always remembers that a plan can change if the visit unfolds new areas to explore.

Further reading:

Fazel and Baillargeon (2011). The health of prisoners. *The Lancet* 2011; 377:956-65. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(10\)61053-7.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)61053-7.pdf)

Lines R (2008). The right to health of prisoners in international human rights law. *International Journal of Prisoner Health*, March 2008; 4(1): 3-53. Available at: https://www.researchgate.net/publication/5469547_The_right_to_health_of_prisoners_in_international_human_rights_law

UN (2000). *The right to the highest attainable standard of health*. Committee on Economic, Social and Cultural rights, 22nd session, Geneva, 25 April – 12 May 2000, Agenda item 3. Available at: http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

WHO (1948). *Constitution of the World Health Organization*. Geneva, 1948. Available at: <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

5.2. Mental health problems

*'Without urgent and comprehensive action, prisons will move closer to becoming twenty-first Century asylums for the mentally ill, full of those who most require treatment and care but who are held in unsuitable places with limited help and treatment available'*²³⁶

Mental health problems are common among prisoners. Prevalence studies show that a very high proportion of prisoners suffer from poor mental health and that prevalence of poor mental health is considerably higher among prisoners than found in the general community.²³⁷ Most of the prevalence studies on mental health problems among prisoners have however been conducted in the Western world and unfortunately very little data is available for non-Western countries. Whether the prevalence of mental health problems is different in those parts of the world is unknown, however, it is likely that prevalences are high across the world.

In this manual, mental health problems refer to a broad range of disorders that affect a person's mood, thinking and behavior. They can vary considerably in clinical manifestation, severity and duration. Mental health problems among prisoners include Post-Traumatic Stress Disorder (PTSD), depression, anxiety, psychosis and a range of personality disorders. Symptoms and clinical manifestations of PTSD and other mental disorders, inter alia voluntary social isolation, anxiety, shyness, depression, passivity, aggressiveness, conflict seeking, and destructive or self-destructive behavior, may be the expression of exposure to traumatic events, including torture or ill-treatment or other abuses from staff members and fellow prisoners. Monitors should have this in mind and should pay particular attention to persons with such symptoms.

Prisoners with a mental health problem are also likely to have several other vulnerabilities, including poor social skills, learning difficulties and intellectual disabilities, as well as poor physical health. An intellectual disability is defined by an IQ score under 70 in addition to deficits in two or more adaptive behaviors that affect everyday living. A study in the USA examined the number of people with disabilities in state and federal prisons and discovered that less than 1% of the prisoners experienced a form of physical disability, while 4.2% experienced a form of intellectual disability.²³⁸ Another study in the USA demonstrated that while those with an intellectual disability comprise 2% to 3% of the general population, they represent 4% to 10% of the prison population, and even higher percentages are found in juvenile facilities and in jails.²³⁹

236 WHO/Europe (2007). *Trencin Statement on prisons and Mental Health*. World Health Organizations Regional Office for Europe, 2007. Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf

237 Singleton et al (1998). *Psychiatric morbidity among prisoners in England and Wales*. London, Office for National Statistics, 1998. Available at: http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publicationsstatistics/DH_4007132

Fazel and Danesh (2002). Serious mental health disorder in 23000 prisoners: a systematic review of 62 surveys. *Lancet* 2002; 359: 545-50. Abstract available at: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(02\)07740-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)07740-1/fulltext)

Fazel and Baillargeon (2011). The health of prisoners. *The Lancet* 2011; 377:956-65. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(10\)61053-7.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)61053-7.pdf)

Fazel et al (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: a systematic review and metaregression analysis of 25 surveys. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2008, 47(9): 1010-1019. Abstract available at: <https://www.ncbi.nlm.nih.gov/pubmed/18664994>

HRW (2009). *Mental Illness, Human Rights and US Prisons*. Human Rights Watch Statement for the Record to the Senate Judiciary Committee. Human Rights Watch, Subcommittee on Human Rights and the Law, 22 September 2009. Available at: <https://www.hrw.org/news/2009/09/22/mental-illness-human-rights-and-us-prisons>

Baranyi G. et al. (2019). Severe mental illness and substance use disorders in prisoners in low-income and middle-income countries: a systematic review and meta-analysis of prevalence studies. *The Lancet Global Health*, Volume 7, Issue 4, April 2019, Pages e461-e471. Available at: [https://doi.org/10.1016/S2214-109X\(18\)30539-4](https://doi.org/10.1016/S2214-109X(18)30539-4)

238 Weiss (2013). People with Intellectual Disabilities and the Prison System. Available at: <http://www.disabled-world.com/disability/types/cognitive/prison-system.php>

239 Petersilia (2000). *Doing justice? Criminal offenders with developmental disabilities*. CPRC Brief, 12 (4), California Policy Research Center, University of California. Available at: <https://files.eric.ed.gov/fulltext/ED465905.pdf>

In the UK, Prison Reform Trust led a programme during 2006-2008 aiming to effect change by exploring the experiences of people with learning disabilities who come into contact with the criminal justice system. The literature review which was part of the programme, showed that in the UK 20-30% of offenders have learning difficulties or learning disabilities that interfere with their ability to cope within the criminal justice system.²⁴⁰ Seven percent of adult prisoners have an IQ of less than 70 and a further 25% have an IQ between 70-79. Around 25% of children who offend have an IQ below 70.²⁴¹

Being imprisoned is particularly difficult for prisoners with a mental health problem that impairs their thinking, way of understanding the environment in which they are living (including other peoples' actions), emotional responses, and coping skills. It has been shown that they are at increased risk of being abused, discriminated and victimized by staff members and fellow prisoners.²⁴²

PTSD is an anxiety disorder which may develop after exposure to a life-threatening event with intense fear and helplessness, including torture or ill-treatment. Because of the high prevalence of Post-Traumatic Stress Disorder (PTSD) among prisoners, the health monitor should be well-aware of its main symptoms and manifestations.

A systematic literature review in 2007 reported that the prevalence of PTSD among prisoners is higher than that in the general population.²⁴³ A more recent systematic review of PTSD prevalence in prison populations was conducted by Baranyi et al in 2017 and included 56 samples from 20 countries worldwide. The authors concluded high prevalence rates. Point prevalence rates ranged from 0.1% to 27% for male prisoners, and from 12% to 38% for female prisoners.²⁴⁴

PTSD is in its manifestations a complex disorder that is particularly relevant when dealing with traumatized persons, including victims of torture and ill-treatment; hence the symptoms and the criteria of the disorder are included here. It is important to be aware that a traumatized person may suffer considerably from some PTSD symptoms without fulfilling the criteria of the diagnosis.

The American Psychiatric Association outlines the following symptoms of PTSD:

1. *'Intrusive thoughts such as repeated, involuntary memories; distressing dreams; or flashbacks of the traumatic event. Flashbacks may be so vivid that people feel they are re-living the traumatic experience or seeing it before their eyes.'*
2. *Avoiding reminders of the traumatic event may include avoiding people, places, activities, objects and situations that bring on distressing memories. People may try to avoid remembering or thinking about the traumatic event. They may resist talking about what happened or how they feel about it.*

240 PRT (2006). *No One Knows: offender with learning difficulties and learning disabilities: the prevalence and associated needs of offenders with learning difficulties and learning disabilities*. Dr Nancy Loucks, Prison Reform Trust, UK, 2006. Available for download at: <https://www.bl.uk/collection-items/no-one-knows-offenders-with-learning-difficulties-and-learning-disabilities-the-prevalence-and-associated-needs-of-offenders-with-learning-difficulties-and-learning-disabilities>

241 PRT (2012). *Fair Access to Justice? Support for vulnerable defendants in the criminal courts*. A PRT briefing paper by Jenny Talbot. Prison Reform Trust, 2012. Available at: <http://www.prisonreformtrust.org.uk/Portals/0/Documents/FairAccess-to-Justice.pdf>

242 UNODC (2009). *Handbook on Prisoners with special needs*, 2009, p15. Available at: http://www.unodc.org/pdf/criminal_justice/ Handbook_on_Prisoners_with_Special_Needs.pdf

243 Goff et al. (2007). Does PTSD occur in sentenced prison populations? A systematic literature review. *Crim Behav Ment Health*. 2007;17(3):152-62. Abstract available at: <https://www.ncbi.nlm.nih.gov/pubmed/17595672>

244 Baranyi et al. (2017). Prevalence of Posttraumatic Stress Disorder in Prisoners. *Epidemiologic Reviews*. Vol.40, 2018. Available at: <https://academic.oup.com/epirev/article/40/1/134/4955401>

3. *Negative thoughts and feelings may include ongoing and distorted beliefs about oneself or others (e.g., "I am bad," "No one can be trusted"); ongoing fear, horror, anger, guilt or shame; much less interest in activities previously enjoyed; or feeling detached or estranged from others.*
4. *Arousal and reactive symptoms may include being irritable and having angry outbursts; behaving recklessly or in a self-destructive way; being easily startled; or having problems concentrating or sleeping*

*Many people who are exposed to a traumatic event, experience symptoms like those described above in the days following the event. For a person with PTSD, however, symptoms last for more than a month and often persist for months and sometimes years. Many individuals develop symptoms within three months of the trauma, but symptoms may appear later. For people with PTSD the symptoms cause significant distress or problems functioning. PTSD often occurs with other related conditions, such as depression, substance use, memory problems and other physical and mental health problems.*²⁴⁵

Another common mental health problem among prisoners is depression, which in some may result in self-harming or suicide attempts.²⁴⁶ Depression is an illness that involves the body, mood, and thoughts of a person and that affects the way in which that person eats, sleeps, feels about himself or herself, and thinks about life. Prisoners with a depression have increased difficulties functioning in places of detention. Depression is likely to be especially common during the first few weeks in a place of detention, because of the prisoner's changed circumstances and conditions and the need to rethink one's life in light of the sentence.

Relevance to preventive monitoring

Prisoners with a mental health problem are in need of appropriate support and treatment. Support and treatment can help some to recover from their disease and for others it can alleviate symptoms, prevent deterioration of the condition, and prevent them from self-harming or committing suicide. Unfortunately, mental health services available to prisoners are often limited and the prison setting is a stressful environment, which impacts on mental health, particularly on the mental health of vulnerable prisoners including those who already had a pre-existing mental health problem before their imprisonment. The mental well-being of any prisoner is likely to deteriorate further when his/her needs are not being met.

Prisoners with a severe mental health problem, such as a psychotic disorder, should in the first place not be in a place of detention, but instead be accommodated in a specialized psychiatric institution. If a prisoner with a severe mental health problem is kept in a place of detention where appropriate treatment and support is not available, this may amount to ill-treatment or torture. An example is when a prisoner with a severe mental health problem is kept in isolation for 24 hours a day because no appropriate daily activities can be offered to him/her by the institution. Another example is when a prisoner with a mental health problem is discriminated, stigmatized or abused by prison staff and/or fellow prisoners because of his/her illness.

The European Court of Human Rights has received several cases relating to the lack of treatment and care available to prisoners with a mental health problem and most of them are found to be violations of article 3 of the European Convention on Human Rights (*"No one shall be sub-*

245 <https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd>

246 Birmingham L. (2004). Mental disorder and prisons. *Psychiatr Bull* 2004; 28:393-7 <https://doi.org/10.1192/pb.28.11.393>
 Lafortune D. (2010). Prevalence and screening of mental disorders in short-term correctional facilities. *Int J Law Psychiatry* 2010; 33:94-100. Available at: <https://www.sciencedirect.com/science/article/pii/S0160252709001344?via%3Dihub>

jected to torture or to inhuman or degrading treatment or punishment'). The following case is an example of a case judged by the Court as a violation of article 3:

M.S. v. the United Kingdom 3 May 2012. The applicant, a mentally-ill man, complained in particular about him being kept in police custody during a period of acute mental suffering while it had been clear to all that he was severely mentally ill and required hospital treatment as a matter of urgency.

The Court held that there had been a violation of Article 3 (prohibition of degrading treatment) of the Convention, finding in particular that, although there had been no intentional neglect on the part of the police, the applicant's prolonged detention without appropriate psychiatric treatment had diminished his human dignity.²⁴⁷

International standards and guidance

Apart from the general Mandela Rules on health care services (Rules 24 – 35) which are of relevance when monitoring the way in which mental health problems are handled by the institution, the Mandela Rules include 2 specific rules addressing prisoners with a mental health problem, stating that persons with severe mental health problems shall not be detained in prisons but instead moved to psychiatric institutions:

Rule 109

1. Persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible.
2. If necessary, other prisoners with mental disabilities and/or health conditions can be observed and treated in specialized facilities under the supervision of qualified health-care professionals.
3. The health-care service shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.

Rule 110

It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric aftercare.

The United Nations Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care (G.A. res. 46/119 1991) outline in Principle 1, paragraph 4:

*'There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals'*²⁴⁸

In 2006, the United Nations adopted the Convention on the Rights of Persons with Disabilities (UNCRPD).²⁴⁹ It adopts a broad categorization of persons with disabilities and reaffirms that all

247 ECHR (2020). *Factsheet – Detention and mental health*. European Court of Human Rights, March 2020. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

248 UN (1991). *United Nations Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care*. United Nations, 1991. Available at: <http://www.un.org/documents/ga/res/46/a46r119.htm>

249 UN (2006). *United Nations Convention on the Rights of Persons with Disabilities*. United Nations, 2006. Available at: https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf

persons with all types of disabilities must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all categories of rights apply to persons with disabilities and identifies areas where adaptations must be made for persons with disabilities to effectively exercise their rights, as well as areas where their rights have been violated, and where protection of rights must be reinforced.

Article 13 of the UNCPRD states that:

1. *'States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.'*
2. *In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.'*

In 2007, the WHO Regional Office for Europe issued the Trecin Statement on prisons and mental health, including six criteria for success to which States and prison authorities should adhere:

1. *There must be a clear acceptance that penal institutions are seldom, if ever, able to treat and care for seriously and acutely mentally ill prisoners*
2. *The vulnerability of newly admitted prisoners must be understood and assessed*
3. *A personal sentence and care plan should be prepared for each individual prisoner, based on both initial and later assessments of needs*
4. *Promoting mental health and well-being should be central to a prison's health care policy.*
5. *Prisons should be resourced to take the necessary steps briefly summarized above. Two essentials are effective leadership by the governor or director and adequate resources to provide a sufficient level of staff with proper initial and continuing training.*
6. *Health care is very important for the general rehabilitation of prisoners.*²⁵⁰

The World Psychiatric Association published a prison health position statement in 2020, stressing the importance of prisoners' timely access 'to the same range, amount and standard of mental health care services that are available to people in the general community'.²⁵¹

The available international standards and guidance are clear and consistent about the fact that persons with a severe mental illness should not be kept in prisons, but instead in specialized institutions where specialized treatment and care is available to them. Nevertheless, many people kept in places of detention suffer from mental health problems to varying degrees and the health monitor should use the above standards and guidance in his/her assessment of how the institution handles these problems and of whether practices are in line with minimum requirements.

250 WHO/Europe (2008). *Trecin Statement on Prisons and Mental Health*. World Health Organization Regional Office for Europe, Copenhagen, 2008. Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf?ua=1

251 Forrester & Piper (2020). The WPA's prison health position statement and curriculum. *World Psychiatry, Official journal of the World Psychiatric Association (WPA)*, Volume 19, Issue 1, 2020. Available at: <https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20711>

Monitoring methodology

Specific questions for the health monitor to investigate prior to the monitoring visit include:

- Where and how are people with a mental health disease and convicted of a crime accommodated in this country and is this in line with national and international legislation?
- Is there any national oversight mechanism on mental health issues in places of detention? And if yes, how does it work, and has it intervened in this institution?

During the monitoring visit, the health monitor should use all sources of information available to him/her, including interviews with prisoners, prison health staff, prison guards and prison management, observations and documentation, in order to properly assess the way in which the institution handles prisoners with a mental health problem and if practices are in line with international standards. The monitor should ask the prison management about general policies and practices in the institution, for instance about where in the institution prisoners with a mental problem are accommodated and whether they can participate in activities with other prisoners.

Interviews with prisoners will give insight into their perspective of how the institution deals with mental health problems. It would be good to interview both prisoners with and without a mental health problem, although selection on purpose will be ethically difficult. In case of a thematic monitoring visit looking into mental health issues, this could be communicated to the prisoners in advance so that those who are willing to talk to the monitoring team could come forward.

Prisoners could for instance be asked about their perception of the way prisoners with a mental health problem are treated in the institution, by staff as well as by fellow prisoners.

A monitor must take good care when interviewing a prisoner with a mental health problem and always keep in mind the possible effect that the interview may have on him/her. For example, prisoners with PTSD need to be interviewed with extreme care because of the risk of re-traumatization. When interviewing a person with a depression, the monitor should make sure not to make the interviewee's feelings of depression, despair and sadness worse and it is advised to keep the conversation as 'light' as possible, i.e. not going into details about feelings but focusing on relations to fellow prisoners and staff and the daily activities in workshops and leisure time. Ideally, a clinical mental health professional should be part of the monitoring team to look specifically into mental health issues. Preferably this is a psychiatrist, a psychologist or an experienced psychiatric nurse. Monitoring mental health issues requires knowledge about the nature of mental health conditions and experience of identifying such conditions and knowledge about treatment of mental diseases currently used as a standard in the country. See for more guidance on interviewing prisoners with a mental health problem, depression or PTSD the chapter on how to conduct health monitoring in Section 2.

Interviews with prison health staff will, amongst other issues, give information on the treatment options available in the institution and the way in which mental health problems are assessed during the initial medical assessment of prisoners upon entry. Prison health staff will be able to outline the main challenges which are faced in the treatment and care of prisoners with a mental health problem.

Interviews with prison guards will mostly result in information about the daily handling of prisoners with a mental health problem and information on any trainings available to staff members, for instance on how to prevent self-harming and suicide among prisoners.

During the entire monitoring visit, the health monitor should use his/her observational skills to get more information on how prisoners with a mental health problem are being dealt with in

the institution. Observations could give the monitor more information on how prisoners with a mental health problem are accommodated and how the interaction with staff members and other prisoners is. Observations should also include noticing any mental health promotion and self-harm prevention initiatives that may be present in the institution.

The final information source which the health monitor should use during his/her monitoring visit are documents, including any written instructions, registers and medical records that can be accessed.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

PRI (2018). *Mental health in prison. A short guide for prison staff*. Penal Reform International, London, 2018. Available at: https://cdn.penalreform.org/wp-content/uploads/2018/05/PRI_Short_guide_to_mental_health_support_in_prisons_WEB.pdf

UN (1991). *United Nations Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care*. United Nations, 1991. Available at: <http://www.un.org/documents/ga/res/46/a46r119.htm>

UN (2006). *United Nations Convention on the Rights of Persons with Disabilities*. United Nations, 2006. Available at: https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

WHO/Europe (2008). *Trencin Statement on Prisons and Mental Health*. World Health Organization Regional Office for Europe, Copenhagen, 2008. Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/99006/E91402.pdf?ua=1

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

5.3. Self-harming and suicide

Self-harming can be defined as the deliberate destruction or alteration of one's own body without conscious suicidal intent. It typically occurs as a manifestation of a psychological or psychiatric disorder. It may however also be a means to overcome any kind of exclusion or to avoid dangerous situations (e.g. torture or abuses from fellow prisoners), for instance with the aim of being transferred to another department or facility, i.e. a call for help or attention.

Suicide refers to the act of intentionally causing one's own death. Suicide is most often a manifestation of a psychological or psychiatric disorder but could also be an impulsive or well-considered act due to stress factors. The definition of suicide differs across countries, with some classifying suicide as any self-inflicted death regardless of the person's intention and others only classifying self-inflicted deaths where there was a clear intention as suicide.

The World Health Organization states that every year about 800.000 people die as a result of suicide and that it is the second leading cause of deaths globally among young people (15-29 years old).²⁵²

As was outlined in the previous chapter, a relatively high proportion of prisoners suffer from mental health problems to varying degrees, with a relatively high risk of self-harming and suicide. In most countries, the rates of self-harm and suicide are higher among prisoners than found in the outside community for both men and women.²⁵³ Suicide is often the single most common cause of death in prison settings, accounting for about half of all deaths.²⁵⁴ Especially the pre-trial and early periods in detention are particularly high-risk times. Suicide figures in places of detention are however different from country to country.

A systematic review of 34 studies on risk factors for suicide in prisoners demonstrated that certain demographic factors (white race/ethnicity, being male, being married), certain criminological factors (occupation of a single cell, detainee/remand status, serving life-sentence), and certain clinical factors (recent suicidal ideation, a history of attempted suicide, a present psychiatric diagnosis (especially psychosis and depression) and a history of alcohol abuse) have clear correlations with suicide in places of detention.²⁵⁵

Hanging oneself is the most common suicide method in places of detention in the majority of countries.²⁵⁶ Other common suicide methods (as reported in Switzerland but known to be common in many countries around the world) include drug overdose and self-immolation.²⁵⁷

Self-harming is far more common than committing suicide, in the community as well as in places of detention. A study in the UK showed that 5–6% of male prisoners and 20–24% of female prisoners self-harmed every year. Repetition of self-harming was shown to be common, particu-

252 See WHO website: <https://www.who.int/news-room/fact-sheets/detail/suicide>

253 Penal Reform International (2007). *Women in prison: incarcerated in a man's world*. London, Penal Reform International (Penal Reform Briefing No. 3), 2007. Available at: <http://www.penalreform.org/wp-content/uploads/2013/06/brf-03-2008-women-in-prison-en.pdf>

254 Fazel and Baillargeon (2011). The health of prisoners. *The Lancet* 2011; 377:956-65. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(10\)61053-7.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)61053-7.pdf)

255 Fazel et al. (2008). Suicide in prisoners: a systematic review of risk factors. *Journal Clin. Psychiatry* 2008; 69: 1721-31. Available at: https://www.researchgate.net/publication/23490177_Suicide_in_prisoners_A_systematic_review_of_risk_factors

256 Bardale and Dixit (2015). Suicide behind bars: A 10-year retrospective study. *Indian J. Psychiatry* 57, 81-84. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4314922/>

257 Gauthier et al. (2015). Swiss prison suicides between 2000 and 2010. *Crisis* 36, pp. 110-116. Available at: <https://doi.org/10.1027/0227-5910/a000302>

larly among women and teenage girls.²⁵⁸ Cutting appears to be the most common method of self-harming. Other methods include (but are not limited to) head banging, hitting, burning and ingesting foreign objects.

Prison authorities have a responsibility in protecting the health and safety of persons kept in places of detention. The provision of adequate suicide and self-harm prevention and intervention services is essential and beneficial to both prisoners and the institution. Several studies have addressed this and critical components of a prison suicide and self-harm prevention program can be summarized as follows:

1. Screening of new prisoners to identify prisoners at-risk
2. Referral of at-risk prisoners to mental health professionals
3. Increased observation and monitoring of at-risk prisoners
4. Staff training and continued risk assessment
5. Fostering positive prisoner-staff and prisoner-prisoner relationships
6. Reduced solitary confinement²⁵⁹, in particular of at-risk prisoners
7. Access to health care services, particularly psychologists and psychiatrists
8. Peer-support programs
9. Strengthening prisoners' contact with the outside world
10. Safer cells and physical prison environment
11. Post-suicide debriefing and learning

Relevance to preventive monitoring

Prison administrations are responsible for protecting the health and safety of their prison population. The failure to do so can lead to acts of self-harming and suicide (attempts) that may have serious consequences, not only for the prisoners who commit those acts, but also for other prisoners who may have found a fellow prisoner severely injured or dead.

Identifying a person at risk of self-harming or committing suicide should be a key element of the initial medical assessment upon entry. If a person is found to be at risk of self-harming or committing suicide, for instance has a history with such acts, the background for the person to resort to these acts should be sought and analyzed in order to minimize future risks. Proper follow-up in terms of care and support and prevention is essential. Prison administrations may fail in the individual suicide/self-harm prevention, i.e. not providing care and support, often because they do not have the facilities and staff to adequately do so. The prison administration may also fail in the general self-harm/suicide prevention by not being vigilant against conditions and situations that make such acts fairly easy to commit or by ignoring individuals' symptoms and behaviors that may indicate risks. This includes failing to provide training to all staff members, to act upon relevant observations, and to implement adequate prevention measures.

258 Hawton et al. (2014). Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *The Lancet*. Volume 383, No. 9923, p1147–1154, 29 March 2014. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(13\)62118-2.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(13)62118-2.pdf)

259 Isolation is shown to be a risk factor for suicide in places of detention. As an example, a study conducted in Italy in 2013 showed that the suicide rate among prisoners in short-term isolation was 239% higher than among other prisoners (232.2 vs 97.8 per 100,000). The suicide rate was even as high as 426.1 among prisoners in maximum security isolation (Roma et al. (2013). Incremental conditions of isolation as a predictor of suicide in prisoners. *Forensic Sci Int*. 2013 Dec 10; 233(1-3) Available at: <https://doi.org/10.1016/j.forsciint.2013.08.016>)

The European Court of Human Rights has received many cases relating to a lack of access to care for prisoners at risk of self-harming or committing suicide and most of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following case is an example of a case judged by the Court as a violation of article 3:

Rivière v. France 11 July 2006. *The applicant complained about his continued imprisonment in spite of his psychiatric problems – he had been diagnosed with a psychiatric disorder involving suicidal tendencies and the experts were concerned by certain aspects of his behaviour, in particular a compulsion towards self-strangulation – which required treatment outside the prison.*

*The Court held that the applicant's continued detention without appropriate medical supervision had constituted inhuman and degrading treatment. It observed that prisoners with serious mental disorders and suicidal tendencies required special measures geared to their condition, regardless of the seriousness of the offence for which they had been convicted.*²⁶⁰

International standards and guidance

Apart from the general Mandela Rules on health care services (Rules 24 – 35), which are relevant when monitoring the way in which self-harm and suicide are handled within the institution, the Mandela Rules include two specific rules addressing prisoners with mental disabilities and/or health conditions which are also relevant to prisoners who are at risk of self-harming or committing suicide. These two rules are outlined in the previous chapter on mental health problems in this Section.

Not an international standard as such, but nevertheless important to refer to, is the specific guidance on preventing suicide in jails and prisons which the World Health Organization issued in 2007 in collaboration with the International Association for Suicide Prevention.²⁶¹ The document mentions the following four key components of a suicide prevention programme: training of correctional staff, intake screening, post-intake observation and management following screening.

According to the guidance document, the following elements should be part of a comprehensive suicide prevention plan for preventing suicides in places of detention:

1. A training programme (including refreshers) for correctional staff and care givers to help them recognize suicidal inmates and appropriately respond to inmates in suicidal crises.
2. Attention paid to the general prison environment (levels of activity, safety, culture and staff-prisoner relationships). In particular, the quality of the social climate of prisons is critical in minimizing suicidal behaviours. While prisons can never be stress-free environments, prison administrators must enact effective strategies for minimizing bullying and other violence in their institutions, and for maximizing supportive relationships among prisoners and staff. The quality of staff-prisoner relationships is critical in reducing prisoners' stress levels and maximizing the likelihood that prisoners will trust staff sufficiently to disclose to them when their coping resources are becoming overwhelmed, feelings of hopelessness, and suicidal ideation.
3. Procedures to systematically screen inmates upon their arrival at the facility and throughout their stay in order to identify those who may be at high risk.
4. A mechanism to maintain communication between staff members regarding high-risk inmates.

260 ECHR (2019). *Factsheet – Prisoners' health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

261 WHO (2007). *Preventing suicide in jails and prisons*. World Health Organization and International Association for Suicide Prevention, 2007. Available at: http://www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf

5. Written procedures which outline minimum requirements for:
 - Housing of at-risk inmates²⁶²
 - Provision of social support
 - Routine visual checks and constant observation for acutely suicidal inmates
 - Appropriate use of restraints as a last resort for controlling self-injurious inmates.
6. Inmates with mental disorders in need of treatment should receive it (pharmacological or psychosocial interventions) and being should be kept under strict observation
7. Development of sufficient internal resources or links to external community-based mental health services to ensure access to mental health personnel when required for further evaluation and treatment.
8. A strategy for debriefing when a suicide occurs aimed towards identifying ways of improving suicide detection, monitoring, and management in correctional settings.²⁶³

Monitoring methodology

Monitors should be informed about existing national principles and regulations on how to prevent and handle cases of self-harm and suicide in places of detention (if available). They should know the most common clinical manifestation of the conditions, which include, but are not limited to: voluntary isolation, depression, passivity, and destructive or self-destructive behavior.

Specific questions for the health monitor to investigate prior to the monitoring visit include:

- What are the number of cases of self-harming and suicide over the last years in this institution (if possible – numbers from the last 5 years)?
- Is this in line with other places of detention and general trends?

During the monitoring visit, the health monitor should use all sources of information available to him/her, including interviews with prisoners, prison health staff, prison guards and prison management, observations and documentation, in order to properly assess the way in which the institution handles and prevents cases of self-harm and suicide (attempts), and if practices are in line with international guidance.

Interviews with prisoners will give insight into their perspective of how the institution deals with self-harming and suicide. It should be attempted to interview both prisoners who have self-harmed or are at increased risk of doing so, and prisoners who did not and are not at increased risk, although selection on purpose will be ethically difficult. In case of a thematic monitoring visit looking into self-harming and suicide, this could be communicated to the prisoners in advance so that those who are willing to talk to the monitoring team could come forward.

Prisoners could for instance be asked about their perception of the way prisoners who have self-harmed are treated in the institution, by staff as well as by fellow prisoners, and about whether they were asked specific questions relating to suicide/self-harming during the initial medical assessment.

A monitor must take good care when interviewing a prisoner who may be at risk of self-harming or committing suicide, and always keep in mind the possible effect that the interview may have on him/her. See for more guidance on interviewing prisoners who likely suffer from a mental

²⁶² This includes housing of an at-risk prisoner in an observation cell without any possibility to commit suicide. Housing an at-risk prisoner in an observation cell should always come before using any kind of restraint measures.

²⁶³ This should include psychological de-briefing of staff and prisoners involved.

health problem, including symptoms of depression, the chapter on interviewing for monitoring purposes in Section 2. Ideally, a clinical mental health professional should be part of the monitoring team to look specifically into mental health issues. Preferably this should be a psychiatrist or psychologist or at least an experienced psychiatric nurse. A monitor who has little or no professional knowledge of psychiatric conditions in general, and depression in particular, and no experience in contact with persons with mental health problems should refrain from taking the lead in interviewing them without any professional backup.

Interviews with prison health staff will, amongst other issues, give information on the way in which risks of self-harming/suicide are assessed during the initial medical assessment of prisoners upon entry. Prison health staff will be able to outline the main challenges which are faced in the treatment and care of prisoners at risk.

Interviews with prison guards will mostly result in information about the trainings available to staff members on how to prevent self-harming and suicide, and on how cases are handled.

The monitor should ask the prison management about general policies and practices in the institution, for instance about where in the institution prisoners who are at risk of self-harming or committing suicide are accommodated and whether they can participate in activities with other prisoners.

During the entire monitoring visit, the health monitor should use his/her observational skills to get more information on the issue. The monitor should for instance assess how the physical conditions in the institution are and whether they are as safe as possible for prisoners at risk of self-harming/committing suicide. He/she should also observe an 'observation cell' where a prisoners at risk of self-harming/committing suicide may be kept.

Last but not least, the monitor should consult available documents, including for instance registers on cases of self-harming or suicide (if available), medical records of prisoners who appear in the registers as being at risk (when having the mandate to consult medical records or otherwise only with informed consent by the prisoner), and the register for psychiatric and psychological consultations.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

PRI (2018). *Mental health in prison. A short guide for prison staff*. Penal Reform International, London, 2018. Available at: https://cdn.penalreform.org/wp-content/uploads/2018/05/PRI_Short_guide_to_mental_health_support_in_prisons_WEB.pdf WHO (2007a).

WHO (2007). *Preventing suicide in jails and prisons*. World Health Organization and International Association for Suicide Prevention, 2007. Available at: http://www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

5.4. Non-communicable diseases

Worldwide, the prevalence of non-communicable diseases (NCDs) is increasing and this constitutes a major public health challenge. Cardiovascular diseases, cancers, diabetes and chronic respiratory diseases are the four most common non-communicable diseases, causing the majority of deaths due to NCDs. The four key risk factors for NCDs, as stated by the World Health Organization, are smoking, harmful use of alcohol, inadequate physical activity and unhealthy diet.²⁶⁴ These risk factors are often highly prevalent in places of detention, due to an unhealthy lifestyle before and during prison stay.

There is a clear link between NCDs and disadvantaged socioeconomic backgrounds and considering that most prisoners come from poor and marginalized sections of society, they are likely to have an increased risk of NCDs.

Most studies addressing NCDs among prisoners stem from high-income countries, which is unfortunate as nearly three quarters of the deaths from NCDs globally occur in low- and middle-income countries.²⁶⁵ Studies show that the prevalence of smokers and people with alcohol abuse on reception into prison is high and some forms of cancer are more prevalent among prisoners compared to the general population.^{266 267} In many countries, food is scarce, especially in places of detention. This often means that prisoners are not getting sufficient calories, or calories from the wrong source, and insufficient nutrients with lots of negative consequences for their health and well-being. The opposite, prisoners getting an excessive amount of calories and little or no physical exercise, can also be the case (most prevalent in high-income countries) and leads to an increased risk of for instance cardio-vascular diseases and diabetes.²⁶⁸

The global burden of NCDs can be remarkably reduced if proper prevention and timely treatment and control is implemented, hereunder among the millions of people who are deprived of their liberty worldwide.

Relevance to preventive monitoring

Ill-treatment is a broad term that refers to a range of acts, conditions and deprivations that amount to cruel, inhuman or degrading treatment or punishment. Some of these cause an increased risk for developing an NCD, such as poor nutrition, poor health care and hygiene, and severe overcrowding, making physical activity difficult or impossible. Lifestyle prevention for deterioration of NCDs, such as small regular healthy meals for diabetics, physical exercise, and avoidance of passive smoking, may be difficult to realize in places of detention and may lead to progression of disease.

Prevention, control and treatment of NCDs is largely neglected in places of detention, both because of the general lack of awareness of the burden of NCDs but also because NCDs are often not considered relevant for the population of prisoners, who tend to be younger than the general population. Also, prevention, control and treatment of NCDs can be costly. It is however a State

264 WHO (2014). *Global status report on noncommunicable diseases*. World Health Organization 2014. Available at: http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1

265 WHO (2014). *Global status report on noncommunicable diseases*. World Health Organization 2014. Available at: http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1

266 Ritter et al. (2011). Smoking in prisons: the need for effective and acceptable interventions. *Journal of Public Health Policy*, 2011, 32(1):32-45. Abstract available at: <https://www.ncbi.nlm.nih.gov/pubmed/21160535>

267 Fazel et al. (2006). Substance abuse and dependence in prison populations worldwide: a systematic review. *Addiction*, 2006, 101(2):181-191. Available at: <http://fazel.org/docs/Addiction%20paper.pdf>

268 Herbert et al. (2012). Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review. *The Lancet*, 2012, 379(9830): 1975-1982. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/22521520>

obligation to provide prisoners with health care services of the same level as in the outside community.

The European Court of Human Rights has received many cases relating to a lack of access to care for prisoners with one or more NCDs and some of them were found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following case is an example of a case judged by the Court as a violation of article 3:

Harutyunyan v. Armenia 15 June 2010. *The applicant suffered from a number of illnesses prior to his detention, including an acute bleeding duodenal ulcer, diabetes and a heart condition. He complained in particular that he had not received adequate medical care in detention.*

*The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention. It observed in particular that, given the number of serious illnesses from which the applicant suffered, he had clearly been in need of regular care and supervision. There was no record in the applicant's medical file of his receiving any check-up or assistance from the detention facility's medical staff. Especially worrying was the fact that his heart attack in July 2004 had coincided with several unsuccessful attempts by his lawyer to draw the authorities' attention to the applicant's need for medical care. In any event, the Court pointed out, a failure to provide requisite medical assistance in detention could be incompatible with Article 3 of the Convention even if it did not lead to a medical emergency or otherwise cause severe or prolonged pain. The applicant was clearly in need of regular medical care and supervision, which was denied to him over a prolonged period. His lawyer's complaints had been met with no substantive response and his own requests for medical assistance had gone unanswered. This must have caused him considerable anxiety and distress, beyond the unavoidable level of suffering inherent in detention.*²⁶⁹

International standards and guidance

The Mandela Rules include three rules which are particularly relevant for monitoring the way in which an institution handles non-communicable diseases and their risk factors. They address the initial medical assessment assessing the specific needs of the prisoner, the right to adequate food, and the obligation of the prison doctor to monitor and react to the living conditions of the prisoners.

Mandela Rule 30 points out that prisoners' overall health situation and health needs are to be assessed upon arrival in detention: *'A physician or other qualified health-care professionals, whether or not they are required to the report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary. Particular attention shall be paid for:*

- (a) Identifying health-care needs and taking all necessary measures for treatment;*
- (b) Identifying any ill-treatment that arriving prisoners may have been subjected to prior to admission;*
- (c) Identifying any signs of psychological or other stress brought on by the fact of imprisonment, including, but not limited to, the risk of suicide or self-harm and withdrawal symptoms resulting from the use of drugs, medication and alcohol; and undertaking all appropriate individualized measures or treatment:*

²⁶⁹ ECHR (2019). Factsheet – Prisoners' health-related rights. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

- (d) *In cases where prisoners are suspected of having contagious diseases, providing for the clinical isolation and adequate treatment of those prisoners during the infectious period;*
- (e) *Determining the fitness of prisoners to work, to exercise and to participate in other activities, as appropriate.*

Mandela Rule 22(l) states that ‘every prisoner shall be provided by the prison administration at the usual hours with food or nutritional value adequate for health and strength, of wholesome quality and well prepared and served’.

Mandela Rule 35 (l) (UN, 2015) outlines that ‘The physician or competent public health body shall regularly inspect and advise the prison director on:

- (a) *The quantity, quality, preparation and service of food;*
- (b) *The hygiene and cleanliness of the institution and the prisoners;*
- (c) *The sanitation, temperature, lighting and ventilation of the prison;*
- (d) *The suitable and cleanliness of the prisoners’ clothing and bedding;*
- (e) *The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities’.*

WHO underlines in its Global Action Plan for the prevention and control of non-communicable diseases the need for addressing ‘the prevention and control of non-communicable diseases and the underlying social determinants through people-centered primary health care and universal health coverage’.²⁷⁰

The global recommendations on physical activity for health, stated by the World Health Organization, state that adults aged 18-64 years should have 150 minutes of moderate physical activity each week to benefit their health.

Prison authorities need to ensure that prisoners have the opportunity to live as healthy as possible. This means for instance that adequate nutrition should be provided (see also the chapter on nutrition in Section 4), regular exercise opportunities should be available, and the harmful effects of smoking and exposure to passive smoking should be kept to a minimum. In many prisons worldwide, overcrowding is a major problem and one of the greatest threats to prisoners’ ability to try to stay healthy and to prison authorities’ ability to improve the situation.

Overall, prisoners should enjoy the same standard of care as available in the outside community, for all health problems including NCDs.

Treatment of NCDs in places of detention

Identification of NCDs in prisoners during the initial medical assessment upon entry is very important (see also the chapter on initial medical assessment in Section 3). Once diagnosed with an NCD, a prisoner needs to be ensured proper access to necessary medical treatment, follow-up, support and care. Continuity of care (including continuous provision of medication and clinical prevention) is of key importance upon arrival in, and upon release from, the institution, and during transfers from one institution to another (see also the chapter on continuity of care in Section 3). Treatment and control of NCDs involves screening, diagnosing, and having access to general as well as specialized medical treatment from arrival to the prison and throughout

²⁷⁰ WHO (2013). *Global action plan for the prevention and control of noncommunicable diseases 2013-2020*. World Health Organization 2013. Available at: http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1

the period of imprisonment (see also the chapter on access to health services in Section 3). It also involves encouraging patients to share responsibility of care, for instance in case of overweight or diabetes.

Prison management and prison health staff should furthermore have in view the prevention of NCDs. As mentioned above, the conditions in the place of detention, including insufficient or poor nutrition, lack of possibilities for physical exercise, and high prevalence of smoking, can contribute to an increased risk of developing an NCD and should be dealt with by prison authorities and assessed by the health monitor.

Monitoring methodology

A monitor should assess the practices in the institution regarding screening, diagnosing, treatment, follow-up and care of patients with non-communicable diseases and the endeavors of the institution to prevent those diseases (reducing risk factors). One of the keys to making useful recommendations for necessary changes is to identify barriers to adequate treatment and prevention enabling the formulation of possible solutions or relevant questions.

Before their visit, monitors should be informed about existing national principles/regulations on prevention and treatment of NCDs (in the community as well as in places of detention). Monitors should look into any accessible documentation addressing non-communicable diseases in the institution. The monitor should be aware of the different non-communicable diseases, their symptoms and risk factors, and be able to identify persons suffering from them.

During the monitoring visit, the health monitor should use all sources of information available, including interviews with prisoners, prison health staff, prison guards and prison management, observations and documentation, in order to properly assess the way in which the institution handles prisoners with a non-communicable disease and to assess whether practices are in line with international standards and guidance.

The monitor should ask the prison management about general policies and practices in the institution, for instance about the health promotion and disease prevention measures in place.

Interviews with prisoners will give insight into their perspective on how the institution deals with non-communicable diseases and how risk factors are reduced. It should be attempted to interview both prisoners who have a NCD and those who have not, although selection on purpose may be ethically difficult. In case of a thematic monitoring visit looking into non-communicable diseases, this could be communicated to the prisoners in advance so that those who are willing to talk to the monitoring team could come forward. As an alternative, prisoners could be selected based on their medical records, but the monitor needs to be very careful in his/her communication on this to the prisoner and ensure the prisoner confidentiality of his/her health status.

Prisoners could for instance be asked about their access to the clinic, their perception of the treatments available including their communication with the health professional, the availability of risk-reducing factors such as access to physical activities and smoke-free areas, and the quality and quantity of the food.

Interviews with prison health staff will, amongst other issues, give information on the treatment options available in the institution and the way in which non-communicable diseases are assessed during the initial medical assessment of prisoners upon entry. Questions that could be asked include the availability of diagnostic tools in the prison health clinic and the role of the prison health staff in the provision of food to the prisoners. Prison health professionals could also be asked about their role in prevention of NCDs in the institution.

Interviews with prison guards will mostly focus on the daily life in the institution. Questions that could be asked, mainly focus on the availability of physical activity and other initiatives, such as anti-smoking campaigns, aimed at reducing risk factors for non-communicable diseases.

During the entire monitoring visit, the health monitor should use his/her observational skills to get more information on how prisoners with a non-communicable disease are being dealt with in the institution and which health promotion and disease prevention initiatives are in place. Observations should also include noticing any health promotion and disease prevention campaigns and an assessment of the prison health clinic with regard to availability of diagnostic tools and access to medication, treatment and support.

The final information source which the health monitor should use during his/her monitoring visit are documents, including any written instructions, registers and medical records that can be accessed.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

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WHO (2013). *Global action plan for the prevention and control of noncommunicable diseases 2013-2020*. World Health Organization 2013. Available at: http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1

WHO (2013). *Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases*. World Health Organization, 2013. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R10-en.pdf

WHO (2014). *Global status report on noncommunicable diseases*. World Health Organization 2014. Available at: http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

WHO (2010). *Global recommendations on physical activity for health*. World Health Organization 2010. Available at: http://apps.who.int/iris/bitstream/10665/44399/1/9789241599979_eng.pdf

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

5.5. Communicable diseases

Communicable diseases, also called infectious or contagious diseases, are caused by microorganisms and can be spread either directly or indirectly from one person to another, by contaminated food or water, or through bites from insects.

Prisoners are at high risk of a range of communicable diseases. The most prevalent communicable diseases and infestations in places of detention are HIV/AIDS, Tuberculosis (TB), hepatitis A, B and C virus, influenza, gastroenteritis, respiratory diseases, scabies and Sexually Transmitted Infections (STIs). Prisoners are at increased risk of entering with a communicable disease, in many cases due to either injecting drug use and poor access to health care prior to their imprisonment. Prison conditions such as overcrowding, poor hygiene, poor ventilation and sanitation as well as lack of preventive and harm reduction measures further increase the likelihood of becoming infected or infested with a disease while in detention. From a human rights perspective it is of high relevance to explore if people have entered the facility with a communicable disease or got the disease within the institution.

Communicable diseases may spread rapidly within places of detention, and as prison populations are not static and prison staff and visitors enter and leave detention facilities every day, there is also a risk for transmission of communicable diseases to other detention facilities and to the outside community.

Below follows a brief summary of the situation with regard to the most common and serious communicable diseases in places of detention.

HIV/AIDS and Hepatitis B and C

The prevalences of HIV, Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) in places of detention throughout the world exceed those in the general population substantially. A review study by Dolan et al. in 2016 has estimated that among the total number of detained people worldwide (10.2 million in 2014), 3,8% are infected with HIV, 15,1% with hepatitis C virus (HCV) and 4,8% have chronic hepatitis B virus (HBV).²⁷¹ Prevalences per region are shown in table 1.

TABLE 1:
PREVALENCE OF HIV, HCV AND HBV IN PLACES OF DETENTION 2005-2015²⁷²

	East and Southern Africa	West and Central Africa	Middle East and North Africa	Asia Pacific	Eastern Europe and Central Asia	Western Europe	North America	Caribbean	Latin America
HIV	15,6%	8,2%	1,3%	1,4%	4,1%	4,2%	1,3%	3,3%	2,3%
HCV	1,8%	16,9%	11,9%	20,6%	20,2%	15,5%	15,3%	No data	4,7%
HBV	5,7%	23,5%	3,3%	4,4%	10,4%	2,4%	1,4%	No data	2,3%

²⁷¹ Dolan et al. (2016). Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *Lancet*. 2016 Sep 10;388(10049):1089-1102. Available at: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2816%2930466-4>

²⁷² Dolan et al. (2016). Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *Lancet*. 2016 Sep 10;388(10049):1089-1102. Available at: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2816%2930466-4>

Transmission of bloodborne viruses such as HIV, HCV and HBV is a huge challenge in places of detention. Factors that contribute to the spread of these viruses include, but are not limited to, sharing of injection equipment, sharing of piercing and tattooing equipment, unprotected sex, sexual violence, rituals where blood is shared, inadequate sterilization of medical equipment or treatment with untested blood products as well as poor health services and lack of preventive measures in general. Preventive measures such as opioid substitution therapy for people who inject drugs, needle and syringe exchange programmes, provision of condoms, and prevention of sexual violence, have been shown to be very effective against the spread of HIV, HCV and HBV.²⁷³ Decreasing the incarceration rate of people who inject drugs would also reduce the burden of HIV, HCV and HBV in detention facilities.

Testing and screening for HIV exists in many correctional facilities on a global scale. However, not all facilities have ensured access to voluntary and confidential testing, which is essential under all circumstances for a prisoner to know his/her status. Forced testing and segregation of HIV/AIDS-infected prisoners is unethical.

Treatment and post exposure prophylaxis (PEP) exist for HIV/AIDS. Treatment is however often disrupted for those who received treatment in the community, when incarcerated in facilities with no or little access to treatment. Furthermore, stigma around HIV/AIDS can cause prisoners not to ask for or take their medication or not to reveal their status while imprisoned. Ensuring treatment for all HIV/AIDS infected prisoners is one effective strategy to reduce HIV transmission in correctional facilities.

Treatment also exists for HCV and chronic HBV infections, but they are not offered in many countries, neither for the general population nor the prison population, as costs are high and treatment is of long duration. Hepatitis B vaccine is key in the prevention of HBV. The World Health Organization recommends the vaccine in low to intermediate endemic areas and for risk groups, including prisoners.²⁷⁴ The reality is, however, that vaccination for HBV may not be offered, neither for the general population nor the prison population, because of high costs and scarcity of health resources.

Even though great challenges exist in detention facilities with regard to the prevention and treatment of HIV/AIDS, HCV and HBV, it is key to remember that detention facilities create a great opportunity for treatment and prevention which can benefit both detainees and the general population. Marginalized groups who do not receive treatment in the community for various reasons, sometimes get an opportunity to access testing and treatment as well as general health care while imprisoned.

Tuberculosis

Tuberculosis (TB) is another serious communicable disease, with a high prevalence of active tuberculosis, multidrug resistant tuberculosis (MDR-TB) and extensively drug resistant tuberculosis (XDR-TB) in places of detention, also in comparison with the general community.²⁷⁵ TB in places of detention is a major public health problem as TB is concentrated in correctional facilities and spreads into the general community through visitors, staff and inadequately treated (former) detainees.

273 Sander G, Shirley-Beavan S, Stone K (2019). The Global State of Harm Reduction in Prisons. *J Correct Health Care*, 2019 Apr;25(2):105-120. Abstract available at: <https://www.ncbi.nlm.nih.gov/pubmed/31084277>

274 WHO. *Hepatitis B factsheet*. Website. Available at: <https://www.who.int/news-room/fact-sheets/detail/hepatitis-b>

275 WHO. *Tuberculosis in prisons*. Website. Available at: <https://www.who.int/tb/areas-of-work/population-groups/prisons-facts/en/>

As for most other diseases, there is generally a lack of data on TB in correctional facilities, which remains a challenge. The review study done by Dolan et al. in 2016 has estimated that among the total number of detained people worldwide (10.2 million in 2014), 2,8% have active TB. The same study has estimated the prevalence of active TB in places of detention in different regions, wherever data was available in the literature, as shown in table 2.²⁷⁶

TABLE 2:
PREVALENCE OF ACTIVE TB IN PLACES OF DETENTION 2005-2015 (DOLAN ET AL 2016)

	East and Southern Africa	West and Central Africa	Eastern Europe and Central Asia
Active TB	5,3%	2,9%	4,9%

In 2011, Fazel et al. published prevalence rates of tuberculosis in the prison population in 8 countries, as shown in table 3.²⁷⁷

TABLE 3:
PREVALENCE OF TUBERCULOSIS IN PRISONERS

	Kazakhstan 2002	Georgia 1997-98	Zambia 2000-01	Russia (St. Petersburg) 2000	Brazil (Sao Paulo) 2000-01	Iran (Qazvin province) 2004-05	Pakistan (Karachi) 2002	Thailand 2004-05
TB	17,8%	6,0%	4,0%	3,2%	2,1%	0,9%	0,7%	0,4%

Data from correctional facilities in 27 countries in the WHO European Region (2015) show that the notification rate of tuberculosis was over 30 times higher in places of detention than in the general population (958 per 100.000 population).²⁷⁸ The World Health Organization has also stated that the level of TB in prisons has been reported to be up to 100 times higher than in the general population and that cases of TB in prisons may account for up to 25% of a country's burden of TB.²⁷⁹

Prison conditions such as overcrowding, poor ventilation and living conditions, poor screening practices, limited access to diagnosis and treatment as well as repeated transfers between facilities increase the vulnerability of prisoners to getting infected with TB. Thus, measures of

276 Dolan et al. (2016) Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *Lancet*. 2016 Sep 10;388(10049):1089-1102. Available at: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2816%2930466-4>

277 Fazel et al. (2011). The health of prisoners. *Lancet*, 2011 Mar 12;377(9769):956-65. Available at: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.837.5370&rep=rep1&type=pdf>

278 WHO/Europe (2018). Good practices in the prevention and care of Tuberculosis and drug resistant Tuberculosis in correctional facilities. World Health Organization Regional Office for Europe, 2018. Available at: http://www.euro.who.int/__data/assets/pdf_file/0003/360543/TB-prisons-9789289052917-eng.PDF

279 WHO. Tuberculosis in prisons. Website World Health Organization. Available at: <https://www.who.int/tb/areas-of-work/population-groups/prisons-facts/en/>

preventing TB include, but are not limited to, sufficient case-finding (ensures early detection and treatment), improvement of prison conditions, and infection control measures (e.g. case isolation and provision of face masks).

The WHO Regional Office for Europe recommends that detection of TB in prisons should be ensured by a combination of screening methods.²⁸⁰ Regarding informed consent on screening for TB, some national legislations allow for examination and treatment of “dangerous” diseases without informed consent from the patient. This may be justified in case positive cases among new prisoners create a risk of an epidemic in the prison population.

TB is treatable and curable. However, the treatment period of TB is long (average 6 months) which can affect compliance negatively, and the continuity of care can be complicated by repeated prison transfers and lack of follow-up after release. Thus, collaboration with community facilities on release is essential –also to avoid MDR- and XDR-Tuberculosis.

Other communicable diseases

Other communicable diseases and infestations worthwhile mentioning in the context of detention facilities are gastroenteritis, influenza, hepatitis A, scabies and STIs such as syphilis, gonorrhea and chlamydia. As mentioned in the beginning of the chapter, the prevalence and incidence of communicable diseases is often an indicator of overcrowding, poor hygiene, contaminated water and poor sanitation as well as insufficient or lack of preventive measures and access to health care. The spread of infectious diseases may further be facilitated by the fact that some prisoners may have an impaired immune defense (e.g. HIV infected persons), which will aggravate the manifestations of other infections.

Relevance to preventive monitoring

Prison authorities need to ensure that prisoners have the opportunity to live an as healthy life as possible within the setting they are in. This means that prisoners should, as a minimum, receive the same standard of prevention, control and treatment for communicable diseases as people living in the outside community.

Denial of prisoners’ right to health may amount to inhuman and degrading treatment. It may deteriorate prisoners’ current and long-term health status and increase their suffering. Exposure to serious infectious diseases that could have been prevented by appropriate action (including preventive measures) by the prison (health) authorities could amount to ill-treatment.

The European Court of Human Rights has received many cases relating to a lack of access to care for prisoners with a communicable disease and most of them were found to be violations of article 3 of the European Convention on Human Rights (*‘No one shall be subjected to torture or to inhuman or degrading treatment or punishment’*). The following case is an example of a case judged by the Court as a violation of article 3 because of lack of sufficient care and treatment of a prisoner with Tuberculosis.

A Ukrainian national who was serving a prison sentence complained that he was subjected to inhuman or degrading treatment while serving his sentence. In particular, he alleged that he did not receive the necessary medical treatment and assistance for tuberculosis. He also complained that the conditions while serving his sentence were unsatisfactory regarding the size of his cell, the number of persons in his cell, the bedding, hygiene, sanitation, ventilation, nutrition and ac-

280 WHO/Europe (2014). Prisons and Health. World Health Organization Regional Office for Europe, Denmark, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

cess to natural light and air. Furthermore, he alleged that he was not provided with the required prescription drugs, medicines and the necessary medical care and attention for his tuberculosis.

*The European Court of Human Rights concluded that the conditions of the applicants' detention as to overcrowding, inadequate medical care and unsatisfactory conditions of hygiene and sanitation amounted to degrading treatment and that there had been a violation of the European Convention on Human Rights, Article 3.*²⁸¹

International standards and guidance

The UN Mandela Rules explicitly mentions HIV, tuberculosis and other infectious diseases in Rule 24 on the necessity to organize health care services in prisons in close relationship with those in the community to ensure continuity of treatment and care. Rule 30 points out that at the initial medical assessment particular attention shall be paid to providing for the clinical isolation and adequate treatment during the infectious period of prisoners suspected of having a contagious disease. Of particular relevance to the prevention of the spread of communicable diseases, Rule 35 outlines that the physician or competent public health body shall regularly inspect and advise the prison director on issues like the hygiene and cleanliness of the institution and the prisoners, and on the sanitation, temperature, lighting and ventilation of the prison, and the suitability and cleanliness of the prisoners' clothing and bedding.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has expressed concerns about the state of preventive measures and treatment for communicable diseases in correctional facilities visited by them. In the CPT standards communicable diseases are explicitly mentioned as well as that prison authorities always have the responsibility to ensure health care and protect prisoners from diseases – also during economically difficult times. The CPT standards outline that:

*'The use of up-to date methods for screening, the regular supply of medication and related materials, the availability of staff ensuring that prisoners take the prescribed medicines in the right doses and at the right intervals, and the provision when appropriate of special diets, constitute essential elements of an effective strategy to combat the above-mentioned diseases²⁸² and to provide appropriate care to the prisoners concerned. Similarly, material conditions in accommodation for prisoners with transmissible diseases must be conducive to the improvement of their health; in addition to natural light and good ventilation, there must be satisfactory hygiene as well as an absence of overcrowding.'*²⁸³

As outlined in the international standards, health care systems within correctional facilities must ensure that any person with symptoms of an infectious disease is appropriately examined and treated without undue delay. It is also their responsibility to facilitate continuity of care after release into the community. Testing for HIV, HBV and HCV should be offered to all newcomers alongside information of consequences of testing/not testing. Informed consent and confidentiality need to be ensured when testing and delivering test results.

Segregation of prisoners infected with a communicable disease should not be done unless this is necessary on medical grounds. As mentioned beforehand, and also stated in the CPT standards, it is not medically justified to segregate HIV-positive prisoners solely on the grounds of their HIV status.

281 ECHR (2006). Case of Melnik v. Ukraine. European Court of Human Rights, 28. Marts 2006. Available at: http://www.hr-dp.org/files/2013/09/06/CASE_OF_MELNIK_v_UKRAINE_.pdf

282 i.e. communicable diseases.

283 CPT (2010). CPT standards, 2002 - revision 2010. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2010. Available at: <https://www.refworld.org/pdfid/4d7882092.pdf>

Furthermore, vaccinations should be offered in prisons at the same indications as in the outside community. However, it could be argued that since the risk of getting infected with certain infectious diseases in prison is high and since the consequences for the infected persons are more serious when their immune system is impaired, vaccinations should be offered at a lower threshold than in the outside community. For instance, in line with the recommendations done by UNODC, free provision of HBV vaccine is recommended for prisoners and staff, considering the many risk factors for transmission that exist in prisons.²⁸⁴

Prison health staff must have access to updated and relevant diagnostic measures (blood tests, sputum tests, x-ray), and be updated and educated on handling and reading test results. Written instructions in line with international standards and national guidelines on disease control, prevention, diagnosis and treatment of the most common communicable diseases, should be available to all health staff. Additionally, health staff should have the possibility to consult with a specialist in infectious diseases. Specialist doctors, particularly when it comes to prevention and treatment of HIV, TB, HBV and HCV, should be directly involved, and the care should be connected to health services in the outside community.

Besides ensuring early diagnosis of communicable diseases, prison authorities must ensure that harm reduction measures are available for all prisoners, and that health education is offered to prisoners, staff as well as visitors to reduce the risk of transmission inside places of detention, between detention facilities, as well as into the outside community.

Monitoring methodology

When monitoring communicable diseases in a place of detention, a monitor should look specifically into the way the institution deals with screening of newcomers, the practice of diagnosing communicable diseases, the way treatment and throughcare are organized and implemented, and the means in place to prevent spread of communicable diseases among prisoners and from prisoners to staff and visitors.

Monitors should assess whether preventive means are in place and working, whether identification of cases is efficient, whether relevant examination of persons in the environment of a contagious patient takes place and whether the medical treatment is in accordance with international standards equal to what is offered to the general population. Furthermore, monitors should assess whether prison health and community health services (e.g. TB- or/and HIV services) are integrated to ensure continuity and completion of treatment for persons imprisoned or released during treatment.

The monitor should ask the prison management about the overall procedures and management of screening, prevention and treatment of communicable diseases. Furthermore, management should be asked if and how they are informed about disease outbreaks in the institution. With regard to prevention, it is essential to ask if they have any harm reduction measures in place in the institution as well as how they inform prisoners and staff on prevention of transmission.

Prison health staff have the most specific and hands-on knowledge about the burden of communicable diseases in the institution and about how communicable diseases are being dealt with. Everything about screening, case finding, prevention, harm reduction measures, treatment and follow-up after release should be explored in the interviews with health staff members. Also, medical ethical dilemmas such as segregation, isolation, informed consent and confiden-

284 UNODC (2014). Policy brief, HIV prevention, treatment and care in prisons and closed settings: a comprehensive package of interventions. 2014. United Nations Office on Drugs and Crime. Available at: https://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

tiality regarding screening procedures should be discussed. Collaboration with specialists in infectious diseases and specialized facilities outside prison should also be explored as well as medical independence – asking health staff if they are able to take clinical decisions without interference by prison management.

The interviews with prisoners should focus on the procedures they went through upon arrival to the institution, hereunder screening for communicable diseases. Furthermore, consent and confidentiality regarding screening procedures should be explored as well as their awareness of any preventive measures in the institution. Prisoners could also be asked about any treatment they may receive, and their overall satisfaction with the way the institution deals with communicable diseases.

When interviewing prison guards, information about their role in the management and the prevention of communicable diseases may be asked.

When doing observations of the prison health clinic, monitors should scrutinize if relevant vaccines and medication are in place, if they are kept in accordance with guidelines (e.g. refrigerator, expiring date), and if they have relevant stock. Diagnostic and screening tools should be made available to the health monitor during these observations. If facilities for isolation of prisoners with communicable diseases exist, these premises should be observed looking for e.g. overcrowding and sanitary facilities. Procedures for isolated infected prisoners should be scrutinized during these observations.

The monitor should assess relevant documents, including any written instructions describing prevention, control and treatment for communicable diseases in the facility as well as medical records from prisoners who have a communicable disease. If available, registers on the number of prisoners with the most common communicable diseases should be scrutinized as well as registers on death in custody.

The monitor should be informed about existing international guidelines and national principles/regulations on prevention – incl. vaccinations - and treatment of the most common and serious communicable diseases and infestations in prisons as well as in the outside community. The World Health Organization has published several international guidelines addressing communicable diseases and issued recommendations on how infection control measures could be conducted in prisons (see also under further reading below).

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Denmark, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

WHO. *Hepatitis A factsheet*. World Health Organization, 2019. Available at: <https://www.who.int/en/news-room/fact-sheets/detail/hepatitis-a>

WHO. *Hepatitis B factsheet*. World Health Organization, 2019. Available at: <https://www.who.int/en/news-room/fact-sheets/detail/hepatitis-b>

WHO. *Hepatitis C factsheet*. World Health Organization, 2019. Available at: <https://www.who.int/en/news-room/fact-sheets/detail/hepatitis-c>

WHO. *HIV factsheet*. World Health Organization, 2019. Available at: <https://www.who.int/news-room/fact-sheets/detail/hiv-aids>

WHO. *TB factsheet*. World health Organization, 2018. Available at: <https://www.who.int/en/news-room/fact-sheets/detail/tuberculosis>

WHO/Europe (2018). *Good practices in the prevention and care of Tuberculosis and drug resistant Tuberculosis in correctional facilities*. World Health Organization Regional Office for Europe, 2018. Available at: http://www.euro.who.int/__data/assets/pdf_file/0003/360543/TB-prisons-9789289052917-eng.PDF

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

Lancet series on HIV and related infections in prisoners (2016), available at: <https://www.thelancet.com/series/aids-2016>

UNODC (2014). *Policy brief, HIV prevention, treatment and care in prisons and closed settings: a comprehensive package of interventions*. United Nations Office on Drugs and Crime, 2014. Available at: https://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

5.6. Substance use disorders

WHO defines substance abuse as *'the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs'*.²⁸⁵ Substance use disorders are reported to be highly prevalent among prisoners upon arrival into an institution and remain a key challenge for prison health.²⁸⁶ They include disorders related to different types of illicit drugs and/or alcohol, where 'disorder' means that the substance use is harmful to the person and/or that the person has developed a substance dependency. In this chapter, the term 'substance use disorder' refers to both 'abuse' and 'dependency' of illicit drugs and/or alcohol.

Illicit drugs

Illicit drugs can be defined as *'substances that either stimulate (such as cocaine or amphetamines) or inhibit (such as heroin or sedative-hypnotics) the central nervous system or cause hallucinogenic effects (such as marijuana or LSD) to the effect that their use has been prohibited globally'*.²⁸⁷ The chronic use of these types of drugs is associated with negative effects on health and risk of the development of dependency.

The global prevalence of drug use (5,5% of the global population aged 15-64) and drug use disorders (0,71% of the global population aged 15-64)²⁸⁸ is magnified in prisons, as many of those who enter prison have a history of drug use and drug use disorders. Based on a total of 149 studies in 62 countries, an estimated one in three people held in prisons worldwide report that they have used drugs at least once while being imprisoned (median and mean = 31%), with one in five reporting use in the past month (median and mean = 19%).

In a systematic review from 2017, including studies from Europe, Australia, New Zealand and the United States, the estimated prevalence of drug use disorders among newly arrived prisoners was 30% [95% CI=22-38%, 13 studies; range 10-61%] among men, and 51% [95% CI=43-58%; 10 studies; range 30-69%] among women.²⁸⁹

The types of drugs used in prisons mainly depend on their availability, price and the geographical region of the institution. According to the World Drug Report 2019, in some regions of the world (such as Eastern/South Eastern Europe), injecting opioids is most common while in other regions oral intake of drugs is more common. Globally, cannabis is the most common drug used in prisons, followed by heroin (approximately 10% of prisoners worldwide report using heroin during imprisonment).²⁹⁰

Despite being prohibited, drugs always find their way into prisons. Although some prisoners may stop using drugs upon entry, others may initiate drug use, initiate use of additional drugs,

285 See WHO website: https://www.who.int/topics/substance_abuse/en/

286 Fazel, Yoon & Hayes (2017). Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addict* Abingdon Engl. October 2017;112(10):1725–39. Available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/add.13877>

287 Definition from: International Encyclopedia of the Social & Behavioral Sciences, 2001. Available at: <https://www.sciencedirect.com/science/article/pii/B0080430767038869>

288 UNODC (2019). World Drugs Report. Global overview of drug demand and supply. United Nations Office on Drugs and Crime, Vienna, 2019. Available at: https://wdr.unodc.org/wdr2019/prelaunch/WDR19_Booklet_2_DRUG_DEMAND.pdf

289 Fazel, Yoon & Hayes (2017). Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addict* Abingdon Engl. October 2017;112(10):1725–39. Available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/add.13877>

290 UNODC (2019). World Drugs Report. Global overview of drug demand and supply. United Nations Office on Drugs and Crime, Vienna, 2019. Available at: https://wdr.unodc.org/wdr2019/prelaunch/WDR19_Booklet_2_DRUG_DEMAND.pdf

or switch to more harmful drug use practices.²⁹¹ Also, drugs often play a key role in committing an offence. The enforcement of punitive drug laws and the criminal justice response to drugs worldwide are contributing to prison overcrowding, especially causing a significant increase in the female prison population. Although the number of women in prison is much lower than the number of men, a higher proportion of women (35%) than men (19%) are in prison for drug-related offences.²⁹² The drug offences, for which many prisoners worldwide are imprisoned, are often minor.²⁹³

Prisoners who use or are dependent on drugs may suffer numerous health consequences. These include, for example, intoxication and acute withdrawal symptoms that may lead to severe conditions or even death if not treated properly. Prisoners who continue or initiate drug use while imprisoned will often do so in an unsafe manner, if preventive measures are not available, and hereby facilitate and increase the spread of communicable diseases. For prisoners who inject drugs, prisons are a high-risk environment for the spread of especially HIV and Hepatitis B and C. This is a result of a high prevalence of both diseases in the prison population, a high prevalence of sharing injection equipment as well as lack of effective harm reduction measures in most places of detention.^{294 295} For example, several outbreaks of HIV and of transmission of viral Hepatitis have been documented in prisons in both Europe and Australia.²⁹⁶

Overdoses, even with death as an outcome, is furthermore a serious health risk that imprisoned drug users suffer, both inside places of detention and in the community upon release. The risk of dying from drug overdose is especially high during the first two weeks after release, which may be explained by abstinence from a preferred drug while in prison, leading to a lower tolerance after release.^{297 298 299 300}

Alcohol

There is a strong link between alcohol and (violent) crime, and the prevalence of alcohol problems in prisoners upon arrival in a place of detention is higher than in the general population.³⁰¹ For example, a systematic review including 10 countries found a prevalence of alcohol use disorder of 24% (95% CI=21-27) among prisoners on reception into prison. The lowest estimates suggest

291 Niveau G, Ritter C. Route of administration of illicit drugs among remand prison entrants. *Eur Addict Res.* 2008;14(2):92–8. Doi: <https://doi.org/10.1159/000113723>

292 According to reports from 50 Member States (UNODC, special data collections on persons held in prisons (2010–2014)). In: UNODC (2019). *World Drugs Report 2019. Global overview of drug demand and supply.* United Nations Office on Drugs and Crime, Vienna, 2019. Available at: https://wdr.unodc.org/wdr2019/prelaunch/WDR19_Booklet_2_DRUG_DEMAND.pdf

293 PRI (2019). *Global Prison Trends 2019.* Penal Reform International, 2019. Available at: https://cdn.penalreform.org/wp-content/uploads/2019/05/PRI-Global-prison-trends-report-2019_WEB.pdf

294 WHO/Europe. *Prisons and health.* World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

295 UNODC (2019). *World Drugs Report. Global overview of drug demand and supply.* United Nations Office on Drugs and Crime, Vienna, 2019. Available at: https://wdr.unodc.org/wdr2019/prelaunch/WDR19_Booklet_2_DRUG_DEMAND.pdf

296 Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. *Lancet Infect Dis.* januar 2009;9(1):57–66. Doi: [https://doi.org/10.1016/S1473-3099\(08\)70305-0](https://doi.org/10.1016/S1473-3099(08)70305-0)

297 Binswanger et al (2007). Release from prison—a high risk of death for former inmates. *N Engl J Med.* 11. January 2007;356(2):157–65. Available at: <https://www.nejm.org/doi/full/10.1056/NEJMsa064115>

298 Fazel and Baillargeon (2011). The health of prisoners. *The Lancet* 2011; 377:956–65. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(10\)61053-7.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)61053-7.pdf)

299 Merrill et al (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addict Abingdon Engl.* September 2010;105(9):1545–54. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2955973/>

300 WHO/Europe (2014). *Preventing overdose deaths in the criminal justice system.* World health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf

301 WHO/Europe. *Prisons and health.* World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

that one in six men and one in ten women had an alcohol use disorder upon arrival into prison.³⁰² A report on the health of prisoners in Australia showed that during the 12 months prior to prison entry, 39% of all prison entrants reported consuming alcohol at high-risk levels.³⁰³ A Scottish research found that even 73% of prisoners had an alcohol-use disorder, with 36% possibly being alcohol-dependent.³⁰⁴

Generally, alcohol possession and consumption are not permitted in places of detention. Imprisonment, however, gives a unique opportunity to tackle alcohol problems. It has been suggested that alcohol problems among prisoners are under-detected, under-recorded and under-treated.³⁰⁵ A heavy overconsumption that is interrupted suddenly may lead to serious withdrawal symptoms that may even be life-threatening. If withdrawal symptoms are not treated, alcohol users may in fact also be at risk of substituting alcohol with an illicit drug available to them in the institution.

Treatment and care for substance use disorders

Prevention, treatment and harm reduction measures are key when caring for prisoners' health. Unfortunately, many places of detention offer inadequate identification procedures and care for prisoners with a substance use disorder, compared to what is offered in the general community.^{306 307 308}

Prisoners with a drug use disorder who have been sentenced to a place of detention instead of to a specific institution for treatment of drug dependency, should be provided with the possibility to get treatment for their disease. Drug dependence treatment is intended to help drug dependent individuals stop compulsive drug seeking and use. Treatment can take many different forms and can last for different lengths of time. For many, treatment is a long-term process. There are a variety of evidence-based approaches to treating drug dependency, which include behavioral therapy (such as cognitive-behavioral therapy), medications, or a combination of the two. There are also a number of less documented methods being applied in practice.

Harm reduction measures in the context of drug use can be defined as harm minimization interventions focused on reducing the negative outcomes of drug use to both substance-using individuals and their communities.³⁰⁹ These are measures that are aimed to reduce adverse health and social consequences of illicit drug use, foremost injecting drug use. They are not a substitute for drug treatment programmes, but instead they should be available complementary. They recognize that abstinence may be neither a realistic nor a desirable goal for some, especially in the short term.

302 Fazel, Yoon & Hayes (2017). Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addict* Abingdon Engl. October 2017;112(10):1725–39. Available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/add.13877>

303 AIHW (2015). The health of Australia's prisoners 2015. Australian Institute of Health and Welfare, 2015. Available at: <https://www.aihw.gov.au/getmedia/9c42d6f3-2631-4452-b0df-9067fd71e33a/aihw-phe-207.pdf.aspx?inline=true>

304 Parkes T et al. (2010). Prison health needs assessment for alcohol problems. Edinburgh, NHS Health Scotland, 2010. Available at: <http://www.ohrn.nhs.uk/resource/policy/PrisonHealthNeedsAssessmentAlcohol.pdf>

305 MacAskill et al (2011). Assessment of alcohol problems using AUDIT in a prison setting: more than an "aye or no" question. *BMC Public Health*. 14 November 2011;11:865. Available at: <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-865>

306 WHO/Europe. Prisons and health. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

307 HRI (2018). The Global State of Harm Reduction 2018. Harm Reduction International, 2018. Available at: <https://www.hri.global/files/2019/02/05/global-state-harm-reduction-2018.pdf>

308 PRI (2019). Global Prison Trends 2019. Penal Reform International, 2019. Available at: https://cdn.penalreform.org/wp-content/uploads/2019/05/PRI-Global-prison-trends-report-2019_WEB.pdf

309 https://www.unodc.org/ddt-training/treatment/VOLUME%20D/Topic%204/1.VoID_Topic4_Harm_Reduction.pdf

Harm reduction measures in the context of injecting drug use include foremost opioid substitution therapy (OST) and needle and syringe exchange programmes (NSEP). Their primary aims are to 'stabilize' the drug user and to prevent the spread of disease, including HIV and hepatitis B/C, among prisoners by reducing the need to use illicit drugs in the first place, and to share needles and syringes if doing anyhow. OST and NSEP are outlined in more detail below, while condom distribution as a harm reduction measure is not directly related to injecting drug use and therefore discussed in the chapter on disease prevention and health promotion in Section 3.

Opioid substitution therapy (OST)

In some countries, especially in the developed world, prisoners with an opioid dependency have access to opioid substitution therapy (OST). OST is the most effective treatment for opioid dependency, but it is also one of the most powerful preventive measures against the spread of HIV and hepatitis B/C among the prison population.^{310 311 312 313} Methadone and buprenorphine are the standard medicines used in OST. Prisoners in treatment are sometimes accommodated together, apart from the rest of the prison population, in order to maintain a treatment-conducive environment. There have been conducted only a small number of studies on the functioning of such 'drug-free' environments/units and their effectiveness in assisting prisoners in reducing/quitting their drug use. Although studies have shown that these environments/units appeal to a large number of prisoners, the effectiveness of these units is not scientifically established.³¹⁴

OST programmes have been introduced in prisons in several countries around the world, with often very positive results. Prison-based OST programmes have shown to be effective in reducing the frequency of injecting drug use and associated sharing of injecting equipment if a sufficient dosage is provided for a sufficient period of time. The risk of transmission of HIV and other blood-borne viruses such as Hepatitis B and C is decreased. Moreover, OST in prison settings has been proven to reduce considerably the excessive mortality of drug users upon release from prison if OST can be continued.³¹⁵

Needle and syringe exchange programmes (NSEP)

An NSEP can be defined as a service that allows injecting drug users to obtain hypodermic needles and associated paraphernalia at no cost. The first NSEP in a prison was established in Switzerland in 1992. Since then, NSEP has expanded to many prisons in countries worldwide, including for instance Spain, Moldova, Romania, Germany, Luxembourg, Tajikistan and Kyrgyzstan. Evaluations of these programmes have demonstrated that NSEPs in prisons are effective at reducing risky behaviours and in fact, do not contribute to increasing injecting drug use. Instead, they have led to significant decreases in overdoses and to increased referrals to

310 WHO/UNODC/UNAIDS (2007). Interventions to address HIV in prisons. Drug dependence treatments. World Health Organization / United Nations Office on Drugs and Crime / Joint United Nations Programme on HIV/AIDS, Geneva, 2007. Available at: https://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf

311 WHO/UNODC/UNAIDS (2004). Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. Position paper. World Health Organization, Geneva, 2004. Available at: www.who.int/substance_abuse/publications/treatment/en/index.html

312 Stover and Michels (2010). Drug use and opioid substitution treatment for prisoners. Harm Reduction Journal, 2020, 7:17. Available at: <https://harmreductionjournal.biomedcentral.com/articles/10.1186/1477-7517-7-17>

313 Kastelic, Pont and Stover (2008). Opioid Substitution Treatment in Custodial Settings. A Practical Guide. Available at: https://www.unodc.org/documents/hiv-aids/OST_in_Custodial_Settings.pdf

314 WHO/UNODC/UNAIDS (2007). Interventions to address HIV in prisons. Drug dependence treatments. World Health Organization / United Nations Office on Drugs and Crime / Joint United Nations Programme on HIV/AIDS, Geneva, 2007. Available at: https://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf

315 WHO/Europe (2014). Preventing overdose deaths in the criminal justice system. World health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf

drug treatment programmes. Moreover, they have been shown to result in improved prisoner health and more prisoners accessing OST, have not led to security or safety issues, and reduce the risk of needle-stick injuries to prison staff.^{316 317}

Relevance to preventive monitoring

Substance use disorders are chronic relapsing disorders and should be treated like any other health condition. Prisoners who use or are dependent on drugs and/or alcohol have the right to access health care, including treatment for substance use disorders. Denial of these rights may amount to cruel and inhuman treatment and facilitate the development of withdrawal symptoms as well as continuation of the substance use, thereby contributing to the spread of blood borne diseases and increase of violence and corruption.

The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, has specified that: *'A particular form of ill-treatment and possibly torture of drug users is the denial of opiate substitution treatment, including as a way of eliciting criminal confessions through inducing painful withdrawal symptoms. The denial of methadone treatment in custodial settings has been declared to be a violation of the right to be free from torture and ill-treatment in certain circumstances'*.³¹⁸

Problems with substance use in prisons are very complex and can be deeply connected to corruption. Drug use is a threat to the security in prisons and often contributes to violence, harassment, discrimination and stigmatization and may lead to extortion and ill-treatment. Attempts to assert control over drug use in prison settings may lead to unrest and even prison riots. In some prisons, drug users are subjected to disciplinary measures and denied treatment because they continue to relapse. Furthermore, drug users are often deeply indebted because of their drug use, which may involve their families who are forced to pay in order to prevent violence against the person. Moreover, some prisoners may be forced by other prisoners to smuggle substances into the institution, making them vulnerable and causing them to enter into the substance use world.

The European Court of Human Rights has received several cases relating to the treatment and care of prisoners with a drug dependency and the handling of withdrawal symptoms and some of them have been found to be violations of article 3 of the European Convention on Human Rights (*'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'*). The following example shows a violation of article 3.

McGlinchey and Others v. the United Kingdom. 29 April 2003.

This case concerned the adequacy of medical care provided by prison authorities to a heroin addict suffering withdrawal symptoms. Sentenced to four months' imprisonment for theft in December 1998, the latter, while in prison, manifested heroin-withdrawal symptoms, had frequent vomiting fits and significantly lost weight. She was treated by a doctor and, as her condition worsened after one week in prison, admitted to hospital, where she died in January 1999. The applicants,

316 HRC (2007). Syringe Exchange in Prisons: The International Experience. Harm Reduction Coalition, 2007. Available at: <https://harmreduction.org/wp-content/uploads/2012/01/harmreductionprisonbrief.pdf>

317 Lines et al. (2005). Taking action to reduce injecting drug-related harms in prisons: The evidence of effectiveness of prison needle exchange in six countries. International Journal of Prisoner Health 1(1):49-64 · March 2005. Available at: https://www.researchgate.net/publication/232992717_Taking_action_to_reduce_injecting_drug-related_harms_in_prisons_The_evidence_of_effectiveness_of_prison_needle_exchange_in_six_countries

318 UN (2013). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. UN Human Rights Council, February 2013. Available at: https://www.ohchr.org/documents/hrbodies/hrcouncil/regularsession/session22/a.hrc.22.53_english.pdf

her children and mother, complained in particular that she had suffered inhuman and degrading treatment in prison prior to her death.

The Court concluded from the evidence before it, in particular the medical records, that the applicants' allegations that the prison authorities had failed to provide their relative with medication for her heroin-withdrawal symptoms and locked her in her cell as a punishment were unsubstantiated. However, with regard to the complaints that not enough had been done, or done quickly enough, to treat the applicants' relative for her heroin-withdrawal symptoms, the Court found that, while it appeared that her condition had been regularly monitored from 7 to 12 December 1998, she had been vomiting repeatedly during that period and losing a lot of weight. Despite some signs of improvement in her condition in the following days, the Court concluded from the evidence before it that by 14 December 1998 the applicants' relative had lost a lot of weight and become dehydrated. In addition to causing her distress and suffering, this had posed very serious risks to her health. The Court found that the prison authorities had failed to comply with their duty to provide her with the requisite medical care, in violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention.³¹⁹

Box 10 includes an example of a case in New York, which was judged to be a violation of prisoners' right to health and their right to be free from cruel and inhuman treatment.

BOX 10:

PUNISHMENT OF DRUG USERS IN NEW YORK STATE PRISONS

'*Barred from Treatment*' is a Human Rights Watch report from 2009, that describes the situation of drug users in prisons in New York. In New York State prisons, three out of four prisoners need substance abuse treatment. Unfortunately, the waiting lists for treatment are long and most prisoners who are dependent on opioids do not have access to treatment. Furthermore, twenty-seven prisoners died of overdose of illicit drugs between 1996 and 2005. In addition to that, prisoners who use and are dependent on drugs may suffer severe punishment.

The report documents the State's failure to ensure access to substance abuse treatment while subjecting drug users to disciplinary measures that bar them from treatment. The following case describes the situation:

'*When Human Rights Watch met with Nathan in July 2008, his hands and feet were shackled with heavy chains. He had been in disciplinary confinement ("the box")—punishment reserved for serious prison offenses—for 14 months. When Nathan entered prison in 2000, he was identified as in need of substance abuse treatment and placed on a waiting list. Because he relapsed into drug use in violation of prison rules, he lost his place on the waiting list, and was sent to the box. Nathan is addicted to opiates and other drugs, and continues to relapse, as is common for people with drug addiction. There is no treatment in the box. Indeed, Nathan has never received any treatment in prison. He now faces another 20 months sentence in the box for using drugs, without access to treatment.*'

The report states that '*New York's severe punishment of drug use in prison, while delaying or denying access to treatment and harm reduction services, violates prisoners' right to health and the right to be free from cruel and inhuman treatment under international law.*'

Reference:

HRW (2009). *Barred from Treatment, Punishment of Drug Users in New York State Prisons*. Human Rights Watch, 2009. Available at: https://www.hrw.org/sites/default/files/reports/nyprisons0309webwcover_0.pdf

International standards and guidance

According to the Special Rapporteur on the right to health, drug dependence is a chronic, relapsing disorder that should be medically treated using a biopsychosocial approach. The Rapporteur highlights that people who use drugs and people who are dependent on drugs have the same right to health as everyone else – even if the use of drugs constitutes a criminal offence. The same standards of medical ethics should be applied to the treatment of drug dependence as to other medical conditions, including the right to refuse treatment. Furthermore, access to health-

³¹⁹ ECHR (2019). Factsheet – Prisoners' health-related rights. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

related information and treatment on a non-discriminatory basis as well as harm reduction programmes should be available for prisoners who either use or are dependent on drugs.³²⁰

In some countries, substance use disorders are still seen as primarily a criminal justice problem and detaining authorities are still responsible for the treatment of affected persons, without supervision by the health agencies. In line with the statement by the Special Rapporteur on the right to health, UNODC and WHO have stated that drug use disorders should be seen primarily as a health problem rather than a criminal behavior and wherever possible, drug users, whose only offence is possession of drugs for personal use, should be treated in the health care system rather than the criminal justice system.³²¹

Several international standards and guidance documents have highlighted the need for drug dependence treatment, treatment of withdrawal symptoms, and the availability of harm reduction measures.

The Mandela Rules include several rules in relation to treatment and care for prisoners with a substance use problem. Rule 30(c) states that *'Particular attention should be paid to Identifying any signs of psychological or other stress brought on by the fact of imprisonment, including, but not limited to, the risk of suicide or self-harm and withdrawal symptoms resulting from the use of drugs, medication or alcohol; and undertaking all appropriate individualized measures or treatment'*. Furthermore, Rule 24.2 outlines that: *'Healthcare services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence'*.

Also the European prison Rules stress in Rule 42.3 (d) that *'when examining a prisoner the medical practitioner or a qualified nurse reporting to such a medical practitioner shall pay particular attention to dealing with withdrawal symptoms resulting from use of drugs, medication or alcohol'*.

In line with the principle of equivalence of care, treatment for a substance use disorder and withdrawal symptoms as well as harm reduction measures in a place of detention should be equivalent to those available in the general community.

WHO, UNODC and UNAIDS have jointly published a set of Evidence for Action papers, including one on interventions to address HIV in prisons: drug dependence treatments. This paper includes a set of 7 recommendations which provide a very useful reference for the health monitor:

1. *Prison authorities in countries in which OST (Opioid substitution therapy), is available in the community should introduce OST programmes urgently and expand implementation to scale as soon as possible.*
2. *Prison authorities should also provide a range of other drug dependence treatment options for prisoners with drug dependence, in particular for other substances such as amphetamine type stimulants.*
3. *Prison authorities should devote particular attention to the availability of treatment and social support services for prisoners on their release, and work in collaboration with relevant authorities to ensure that comprehensive aftercare services are available.*

320 UN (2015). *Study on the impact of the world drug problem on the enjoyment of human rights. Report of the United Nations High Commissioner for Human Rights*. UN General Assembly, 2015. Available at: http://www.unodc.org/documents/un-gass2016/Contributions/UN/OHCHR/A_HRC_30_65_E.pdf

321 UNODC/WHO (2017). *International standards for the treatment of drug use disorders. Draft for field testing*. United Nations Office on Drugs and Crime, 2017. Available at: https://www.who.int/substance_abuse/activities/msb_treatment_standards.pdf

4. *States should affirm and strengthen the principle of providing treatment, counseling, education and rehabilitation as an alternative to conviction and punishment for drug-related offences.*
5. *Prison systems should provide prisoners with the option of living in a 'drug-free' environment.*
6. *Improving the documentation and evaluation of supply reduction measures should be a priority for prison systems making substantial investments in such measures.*
7. *Prison systems with mandatory drug testing programmes should reconsider urine analysis testing for cannabis. (At a minimum, they should make clear distinctions between those testing positive to cannabis and opiates, as injecting opiates presents a significant risk of HIV infection while smoking cannabis presents no risk of HIV transmission).³²²*

Substance use disorders should be identified at the initial medical assessment to ensure timely treatment for dependency and withdrawal symptoms. Relevant and individual treatment (OST/ other treatment) should be offered in accordance with the prison guidelines (if any exist). Furthermore, health education should be available already upon admission.

Prison staff members should be appropriately trained to effectively engage with the treatments for drug and alcohol use disorders, which includes knowing symptoms and signs and withdrawal symptoms, knowing the treatment possibilities that exist in the prison, having a respectful approach towards persons with a substance use disorder with the aim of motivating them to address the clinic, and acknowledging the obligation to report to the prison administration any observation of drug trafficking and trading. It should be clearly outlined to prison staff what their role is in the prevention and handling of substance use, including supervising substance users. Prison staff does not have the ultimate responsibility to identify or treat substance users, as this responsibility lies with the prison health services. Prison health professionals should also pay specific attention to medical emergencies for substance users (withdrawal symptoms and acute drug intoxication), which includes referral to intensive care if needed. Care offered to prisoners after release from the institution should include follow-up as well as provision of information about the increased risk of overdose after release. This is essential to protect prisoners from increased morbidity and mortality.

One could surely argue that there is a need for intensified checks and searches to prevent drugs coming into and spreading around in places of detention in the first place. However, prison health professionals should never be involved in drug checks and searches and should not agree to body searches or drug tests done for security reasons only. Prison health professionals often face a dual obligation dilemma here, on one hand towards the prison authorities and on the other hand towards their patients whose trust they are likely to lose when they participate in these kind of checks and searches (see also the chapter on the role of the prison health professional and dual obligation dilemmas in Section 3).

Prison health professionals share the responsibility with the prison administration to offer support (which may include transfer to another section of the prison) to all prisoners, including substance users, if they experience any form of stigmatizing or abuse.

In all countries where OST programmes are implemented in the community, they should also be implemented in prison settings (principle of equivalence of care). This is also critical for the continuity of treatment and care for people on OST when entering the criminal justice system. Treatment interruption often leads to severe withdrawal symptoms in an already very vulnerable

322 WHO/UNODC/UNAIDS (2007). *Interventions to address HIV in prisons. Drug dependence treatments*. World Health Organization / United Nations Office on Drugs and Crime / Joint United Nations Programme on HIV/AIDS, Geneva, 2007. Available at: https://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf

period for prisoners upon entry in the criminal justice system and it may result in resuming injecting drug use (in an often unsafe manner in the prison setting).

To reduce the risk of opioid overdose in persons after release from prison, persons with a history of opioid use (and possibly also their families and friends) could be given naloxone to take home along with training in its use in the management of opioid overdose.³²³ They should also be ensured continuation of treatment by means of a referral to an appropriate treatment programme.

Effective detection of alcohol problems, preferable with a validated screening tool, in prisoners upon entry in the institution is a key first step in addressing alcohol use disorders. The WHO Alcohol Use Disorders Identification Test (AUDIT) screening tool is considered a promising tool to use in places of detention. The tool can help identify excessive alcohol consumption and has the ability to differentiate between different patterns of drinking behavior. It comes in two versions, one for self-administration and one for interviewer administration.^{324 325 326}

Treatment for alcohol withdrawal symptoms should be available for all prisoners. Alcohol is one of the most dangerous substance from which to withdraw and can turn into Delirium Tremens – a very serious condition with a high risk of mortality if not treated timely and correctly.

It is the obligation of the State to protect prisoners' right to health – hereunder access to treatment for substance use disorders, treatment for health emergencies related to substance use disorders (intoxication and acute withdrawal symptoms), throughcare, aftercare and access to harm reduction measures. This should be available in all places of detention.

Monitoring methodology

The health monitor should collect information on the following:

- a. Screening of newly arriving prisoners. E.g. are recognized and validated screening tools for substance use and dependency in use?
- b. The availability of treatment and support. E.g. are opioid substitution therapy and needle exchange programmes available, as well as after-care upon release?
- c. The use of body searches, urine samples and disciplinary measures (see also Section 4, chapters on the use of body searches and on the use of urine samples). In particular, is denial of treatment and/or harm reduction measures ever used as a sanction?
- d. Drug-related deaths and violence in the institution. E.g. How many drug-related deaths and violent episodes have taken place in this institution over the last years? Are any preventive measures taken based on an analysis of cases? (see also the chapter on death in custody in this Section)

323 WHO/Europe (2014). *Preventing overdose deaths in the criminal justice system*. World Health Organization Regional Office for Europe, 2014 (re-print from 2010). Available at: http://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf?ua=1

324 Babor et al. (2001). *The Alcohol Use Disorders Identification Test - Guidelines for Use in Primary Care*. World Health Organization, 2001. Available at: http://apps.who.int/iris/bitstream/handle/10665/67205/WHO_MSD_MSB_01.6a.pdf?sequence=1

325 WHO/Europe. *Prisons and health*. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

326 WHO/Europe. *Alcohol problems in the criminal justice system: an opportunity for intervention*. World Health Organization Regional Office for Europe, 2012. Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/181068/e96751-ver-2.pdf

- e. Drug- and alcohol-related abuse (prevalence) and violence in the institution. E.g. have there been any violent incidents over the last years? Are any preventive measures taken based on an analysis of cases (see also the chapter on violence in this Section)
- f. Information to prisoners about substance use, health consequences and available treatment and harm reduction measures in the institution.
- g. Training and written instructions to staff members.

The monitor should ask the prison management if there is a strategy to fight and treat substance use in the institution and if it is in accordance with the national strategy, including what kind of services the institution offers. The prison management should have an overview of the characteristics of the problem in the institution, including deaths relating to substance use. Furthermore, prison management can inform the monitoring team on the regime for controlling drugs (body searches, searches, urine samples etc.) and whether there are any disciplinary measures for prisoners if they possess or use drugs.

Interviews with prisoners should focus on experiences with screening on entrance, treatment (voluntary?), preventive measures and health education. Prisoners can also give information on disciplinary measures for possessing or using drugs and if they have experience with that. Furthermore, they could be asked whether they experience any stigmatization or ill-treatment of substance users in the institution.

Prison health staff are a very useful information source on all the specifics regarding treatment and care for prisoners with a substance use disorder. They can describe in detail the institution's policy on treatment of drug and alcohol disorders as well as preventive measures, and reveal if the policy is implemented. They would also have a good overview of the problem with regard to substance use in the institution, as they treat prisoners who overdose or have withdrawal symptoms and are aware of deaths due to either or both. Prison health professionals could inform the monitoring team on screening of prisoners upon entry, including screening tools and what measures are taken if a prisoner arrives in an institution with acute withdrawal symptoms. Finally, throughcare and after-care as well as collaboration with relevant facilities in the community could be explored in the interviews with prison health staff.

Prison guards will be able to give the monitor information on their view on the problems with drugs and alcohol in the institution – information that could differ significantly from information given by the management and health staff. Prison guards often receive prisoners at entry and have knowledge on whether screening for substance use and withdrawal symptoms is effective and implemented and whether the right and timely treatment and care is offered in the institution. If an institution has limited available health staff (e.g. only once a week or once every second week), prison guards would often be the first ones dealing with withdrawal symptoms. Furthermore, stigmatization, drug-related violence and corruption as well as drug types used in the institution could be explored in the interviews with prison guards. Finally, prison guards could inform the health monitor on harm reduction measures, regimes for controlling substance use (e.g. body searches, urine tests, search of cells etc.) and disciplinary measures for possessing or using substances in the institution.

Observations could for instance include whether any harm reduction measures are visibly in place (such as availability of clean needles and syringes) and how they can be accessed by the prisoners.

The monitor should assess written instructions on all relevant areas of substance use. If any statistics/registries on disciplinary measures given for possessing or using substances, cell

searches, body searches or urine tests (including results) exist, then they should be reviewed by the monitoring team. If relevant, monitors should also look into individual case reports from prisoners suffering from a substance use disorder.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

UN (2015). UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UNODC (2019). World Drugs Report. Global overview of drug demand and supply. United Nations Office on Drugs and Crime, Vienna, 2019. Available at: https://wdr.unodc.org/wdr2019/prelaunch/WDR19_Booklet_2_DRUG_DEMAND.pdf

UNODC (2008). Reducing the adverse health and social consequences of drug abuse: A comprehensive approach. Discussion paper. United Nations Office on Drugs and Crime, 2008. Available at: <http://www.unodc.org/documents/prevention/Reducing-adverse-consequences-drug-abuse.pdf>

WHO Europe (2014). Preventing overdose deaths in the criminal justice system. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf

WHO/Europe(2012). *Alcohol problems in the criminal justice system: an opportunity for intervention*. World Health Organization Regional Office for Europe, 2012. Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/181068/e96751-ver-2.pdf

WHO/UNODC/UNAIDS (2007). *Interventions to address HIV in prisons. Drug dependence treatments*. World Health Organization / United Nations Office on Drugs and Crime / Joint United Nations Programme on HIV/AIDS, Geneva, 2007. Available at: https://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf

5.7. Oral health

WHO defines oral health as “a state of being free from chronic mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual’s capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing”³²⁷

The term oral health is often used interchangeably with dental health. In this chapter oral health is used as an umbrella term including all oral issues and diseases, while dental health refers merely to issues with the teeth.

Globally, the burden of oral diseases is high. Oral diseases are in fact the ‘most common noncommunicable diseases and affect people throughout their lifetime, causing pain, discomfort, disfigurement and even death’.³²⁸ Access to oral care is however limited in most low- and middle-income countries and oral health is often a neglected area in public health.

Many prisoners suffer from poor oral health upon entry into an institution and oral health problems are considerably more prevalent in the prison population than in the general population.³²⁹ Prisoners have been shown to have significantly more decayed and missing teeth and fewer filled teeth and restorations than people living in the general community. A high prevalence of periodontal disease has been recorded, worsened by the high proportion of prisoners who smoke, use substances and have habits, such as teeth-grinding or nail-biting, that can affect oral health negatively.

Prisoners have often had limited access to oral health care before their imprisonment. Moreover, behavioural risk factors for oral diseases are shared with other major NCDs like cardiovascular diseases, cancer, chronic respiratory diseases and diabetes. These include for instance an unhealthy diet high in free sugars, tobacco use and harmful use of drugs or alcohol.³³⁰ The prevalence of substance use and mental health disorders is known to be high in places of detention. Neglect of health, including oral health, exists in both groups, and many types of drugs, both illicit drugs and psychotropics, can damage the teeth and gums.³³¹

Prevalence of communicable diseases like HIV are also known to be high in the prison population and there is a clear correlation between HIV and oral diseases. According to a USA-focused paper in 2005, oral manifestations occur in 30–80% of people with HIV.³³² There are however considerable variations depending on for instance affordability of antiretroviral therapy. Oral manifestations of HIV include fungal, bacterial or viral infections of which oral candidiasis is the

327 <https://www.who.int/news-room/fact-sheets/detail/oral-health>

328 <https://www.who.int/news-room/fact-sheets/detail/oral-health>

329 Cunningham, M.A. et al. (1985). Dental Disease Prevalence in a Prison Population. *J. Public Health Dent.* 45, March 1985. Available at: <https://doi.org/10.1111/j.1752-7325.1985.tb03845.x>

Heidari, E. et al. (2007). Oral health of remand prisoners in HMP Brixton, London. *Br. Dent. J.* 202, E5–E5. Available at: <https://doi.org/10.1038/bdj.2007.32>

Jones, C.M. et al. (2005). Dental health of prisoners in the north west of England in 2000: literature review and dental health survey results. *Community Dent. Health* 22, 113–117. Abstract available at: <https://www.ncbi.nlm.nih.gov/pubmed/15984137>

Nobile, C.G.A. et al. (2007). Oral health status of male prisoners in Italy. *Int. Dent. J.* 57, 27–35.

330 <https://www.who.int/news-room/fact-sheets/detail/oral-health>

331 Fratto, G. & Manzoni, L. (2014). Use of psychotropic drugs and associated dental diseases. *Int. J. Psychiatry Med.* 48, 185–197. Available at: <https://doi.org/10.2190/PM.48.3.d>

332 Reznik DA (2005). Oral manifestations of HIV disease. *Top HIV Med.* 2005;13(5):143-148. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3220059/>

most common and often the first symptom early in the course of the disease. Oral HIV lesions cause pain, discomfort, dry mouth, as well as eating restrictions.³³³

Accessibility to good-quality oral health services as well as oral health promotion is of key importance and even more so in places of detention where prisoners reside for longer periods of time. Unfortunately, resources are scarce in many developing countries and the availability of oral health services and dental health care equipment in places of detention is often limited.

Other barriers to oral health exist both among prisoners (e.g. lack of information and anxiety) and within the system (e.g. long waiting lists, appointments clashing with legal and family visits, transfers between institutions and lack of available escort to take prisoners to dental appointments).³³⁴ Reducing these barriers by health promotion initiatives and by changes within the prison health care system could improve oral health of prisoners. A dental health promotion campaign in prison should, inter alia, inform about the necessity to maintain good oral hygiene, about how to get the necessary dental tools, about how to access the prison dentist for regular check-ups and in case of urgent dental problems /pain, and about the possibility to get anesthesia before a necessary painful treatment. Dental kits with basic dental tools should be made available for all, free of charge. As demonstrated by a study conducted in England in 2007, dental health as well as hygiene was indeed improved by increasing availability of basic dental tools such as toothbrushes, toothpaste with fluoride and dental floss and dental picks.³³⁵

Severe oral health issues may complicate a prisoner's life after release, for instance because of financial stress due to costs related to continued treatment, poor health appearance when searching for a job, pain and suffering, and social stigma. As stated by the WHO Regional Office for Europe: '*Good oral health enables individuals to communicate effectively and is important to the overall quality of life, self-esteem and social confidence*'.³³⁶

Relevance to preventive monitoring

Not providing prisoners with a level of oral health care that is equivalent to that provided in the local community may have serious consequences for the individual and his/her overall health status. It may in some cases be regarded as inhuman or degrading treatment. For instance, not providing dental treatment as available in the local community is likely to lead to the development and progression of dental health problems, causing unnecessary pain and suffering and in worst case causing serious infections, such as sepsis, endocarditis and osteomyelitis, all having a severe impact on general health and well-being.

The European Court of Human Rights has received several cases relating to a lack of access to dental health services for prisoners. The following case is an example of a case judged by the Court as a violation of article 3 of the European Convention on Human Rights ('*No one shall be subjected to torture or to inhuman or degrading treatment or punishment*')

V.D. v. Romania (no. 7078/02) 16 February 2010. Having serious dental problems (he has virtually no teeth), the applicant required a dental prosthesis, a fact recorded by doctors on several occasions while he was in prison. But he was unable to obtain them as he did not have the means to pay.

333 <https://www.who.int/news-room/fact-sheets/detail/oral-health>

334 Jones, C.M. et al. (2005). Dental health of prisoners in the north west of England in 2000: literature review and dental health survey results. *Community Dent. Health* 22, 113–117.

335 Heidari, E. et al. (2007). Oral health of remand prisoners in HMP Brixton, London. *Br. Dent. J.* 202, E5–E5. Available at: <https://doi.org/10.1038/bdj.2007.32>

336 WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

*The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention. It observed in particular that, as far back as 2002, medical diagnoses had been available to the authorities stating the need for the applicant to be fitted with dentures, but none had been provided. As a prisoner, the applicant could obtain them only by paying the full cost himself. As his insurance scheme did not cover the cost and he lacked the necessary financial resources – a fact known to and accepted by the authorities – he had been unable to obtain the dentures. These facts were sufficient for the Court to conclude that the rules on social cover for prisoners, which laid down the proportion of the cost of dentures which they were required to pay, were rendered ineffective by administrative obstacles. The Romanian Government had also failed to provide a satisfactory explanation as to why the applicant had not been provided with dentures in 2004, when the rules in force had provided for the full cost to be met by the State. Hence, despite the concerns about his health the applicant had still not been fitted with dentures, notwithstanding new legislation enacted in January 2007 making them available free of charge.*³³⁷

The role and the responsibilities of dentists involved in the care of people deprived of their liberty are the same as apply to other health care professionals. Dentists have an obligation towards prisoners and the society to report shortcomings in care and systematic abuse, including torture and ill-treatment. Furthermore, they share the obligation of documenting cases of violence and torture, similar to physicians.

Apart from a lack of access to dental treatment amounting to ill-treatment, oral health issues could also be the direct consequence of violence or torture. Methods of torture causing dental injury include beatings and kicks to the head or face, as well as teeth extraction.

Dental torture is described in the Istanbul Protocol as follows:

*‘Dental torture may be in the form of breaking or extracting teeth or through application of electrical current to the teeth. It may result in a loss or breaking of the teeth, swelling of the gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures or loss of fillings from teeth. Temporomandibular joint syndrome will produce pain in the temporomandibular joint, limitation of jaw movement and, in some cases, subluxation of this joint due to muscle spasms occurring as a result of the electrical current or blows to the face.’*³³⁸

International standards and guidance

It is stressed in both the Mandela Rules (Rule 25) and the CPT Standards (standard 35) that ‘the services of a qualified dentist shall be available to every prisoner.’

The World Dental Federation issued ‘Guidelines for Dentists against Torture’, which state that:

‘Whilst respecting generally acknowledged patients’ rights, dentists must have complete clinical independence in deciding upon the care of persons for whom they are dentally responsible. The dentists’ primary role is to alleviate the dental distress of their fellow human beings and no motive, whether personal, collective or political, shall prevail against this higher purpose.’

And furthermore:

‘The dentist shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures

³³⁷ ECHR (2019). *Factsheet – Prisoners’ health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

³³⁸ UN (2004). *Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations Office of the High Commissioner for Human Rights, 2004. Available at: <https://www.ohchr.org/Documents/Publications/training8rev1en.pdf>

*is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.*³³⁹

WHO Regional Office for Europe recommends that oral health is included in prison health programmes and is an integral part of the prison health service provision. Furthermore, it is recommended that the initial medical assessment of prisoners upon entry into an institution should include a focus on oral health and that a dental care professional should be part of the medical team.³⁴⁰ If this is not feasible, the initial medical assessment should at least include questions about oral health history and current symptoms, with a view to referring those in need of treatment. Prisoners with dental traumas should always be referred to a dentist. Repair of diseased teeth should be endeavored whenever possible and extraction of teeth should be regarded as a last resort.

While in prison, both prisoners and prison health staff should be able to refer to a dentist with a not too long waiting time. Dental conditions may be extremely painful, hence emergency services should be available. Dentists, like any other health care provider, should keep a record of examinations and treatments and the record should be transferred with the patient upon release or transfer to another institution, ensuring continuity of care. Ideally, a copy of the record should be handed to the prisoner on release or - with the consent of the prisoner - be sent to the prisoner's dentist in the community (if any).

Good oral health, as part of a good general health status, is the shared responsibility of the state authorities, prison management, prison health staff and the prisoners themselves. The organizational structure of dental care varies between institutions, regions and countries. To provide an efficient and effective dental service, the dental team must have a good understanding of the prison structures and processes. Prisoners should be well-informed and encouraged to take part in taking care of their own oral health using the necessary equipment provided by the institution and the dental health services available.

Monitoring methodology

The monitor should assess the practices in the institution regarding screening, diagnosing, treatment, follow-up and care of prisoners' oral health and the prevention and health promotion actions in place.

Before the visit, the monitor should be informed about existing international and national standards/principles for oral care in prisons and should know the general standards existing in the community. He/she should look into any accessible documentation addressing oral health issues in the institution.

During the monitoring visit, the monitor should use all the different information sources available to him/her to assess the above-mentioned issues and whether or not they are in line with international standards.

The monitor should ask the prison management about general policies and practices in the institution, for instance on whether the institution has (had) any oral health promotion campaigns and how a prisoner with acute tooth pain can be assured access to a dentist.

339 FDI World Dental Federation (2007). *Guidelines for Dentists against Torture*. World Dental Federation, Dubai, October 2007. Available at: file:///C:/Users/BB/Downloads/fdi_world_dental_federation_-_guidelines_for_dentists_against_torture_-_2018-07-02.pdf

340 WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

Interviews with prisoners should focus on getting more information on how the system of oral health care in the institution functions. Questions that could be asked include whether the prisoner was asked any questions about their oral health status upon entry into the institution, how often he/she has the possibility to undergo an examination by a dentist, and which treatment has been offered based on a diagnosed condition.

When assessing issues regarding oral health in the institution, it is vital to interview the dentist (and any dental assistants) present in the institution. The dentist will be able to provide the monitor with information about the dental health practices in the institution, including how prisoners can access the dentist (acute and regularly for check-ups), the capacity of the dental clinic, how the oral health status of the prisoners in the institution is in general, whether he/she ever encountered a case of poor dental health which may have been, or clearly was, the result of violence or torture, and what his/her follow-up was on this case.

Other prison health staff could for instance be asked about how regular and emergency dental care is managed in case of absence of the dentist.

Interviews with prison guards should foremost focus on the role prison guards may play in prisoners having access to dental health care, and on any oral health promotion initiatives that may be or have been present in the institution.

During the entire monitoring visit, the health monitor should use his/her observational skills to get more information on how oral health is being dealt with in the institution and which health promotion and disease prevention initiatives are in place. Observations should include an assessment of the dental clinic with regard to cleanliness, availability of tools and instruments, access to medication and availability of treatment and support. Observations should also include noticing the oral health status of prisoners (during interviews) and noticing any oral health promotion and oral disease prevention campaigns in place.

The final information source which the health monitor should use during his/her monitoring visit are documents, including any written instructions, registers and medical records that can be accessed. This includes looking into the dentist records and registers, when possible triangulating with medical records.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2010. Available at: <https://www.refworld.org/pdfid/4d7882092.pdf>

FDI World Dental Federation (2007). *Guidelines for Dentists against Torture*. World Dental Federation, Dubai, October 2007. Available at: file:///C:/Users/BB/Downloads/fdi_world_dental_federation_-_guidelines_for_dentists_against_torture_-_2018-07-02.pdf

UN (2004). *Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations Office of the High Commissioner for Human Rights, 2004. Available at: <https://www.ohchr.org/Documents/Publications/training8rev1en.pdf>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

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5.8. Special needs

Certain groups of prisoners are considered to be especially vulnerable within the context of a place of detention and may therefore have special needs. Vulnerable, in this context, means that these groups are more harmed, or at risk of being more harmed, than others, either more frequently or more seriously. Such vulnerable groups may include minors, elderly, foreign nationals, religious minorities, ethnic minorities, prisoners with disabilities, and lesbian, gay, bisexual, transgender and intersex (LGBTI) prisoners, and these groups are the focus of this chapter. They may have special needs in terms of increased attention, protection and/or support, and the needs may very well be health-related, including health protection, treatment and medication.

Minor prisoners

In law, the definition of a minor depends on jurisdiction and its application, however minor is generally referring to a person under the age of 18. The total number of prisoners under the age of 18 was estimated to be about one million in 2010.³⁴¹ Minor prisoners are likely to have special needs regarding their physical growth, meaning that sufficient and adequate nutrition and physical exercise are very important. Also, their mental health needs need prioritized attention, taking into consideration the long-term damaging effects of detention and the psychological fragility considering their age and level of maturity. Moreover, minor prisoners have an increased need for educational programmes and for being in close contact with their family.

Elderly prisoners

The number of elderly prisoners in places of detention throughout the world is rapidly rising, concurrently with the ageing of the general population. This is particularly true in high-income countries.³⁴² The ages of 60 and 65 are often used as cut-off points to divide between older and younger cohorts of the population. Elderly prisoners may be physically less mobile and thus have a need for specific accommodation that takes into account the risks for both falls and social isolation. Moreover, elderly prisoners are more prone to a range of diseases and are more often in need of regular health checks and medical treatment. The increasing number of elderly prisoners who suffer from age-related conditions, causes an increasing proportion of deaths in places of detention resulting from natural causes, such as coronary heart diseases and cancers.³⁴³

Prisoners with physical disabilities

Data on the number of prisoners with physical disabilities is scarce. The number is, however, expected to rise concurrently with the ageing of the prison population. Physical disabilities include a broad range of conditions, such as difficulties with seeing, hearing, speaking and being mobile, which may or may not occur as secondary conditions to both communicable and non-communicable diseases as well as treatment. The difficulties that people with disabilities face in society are typically magnified in places of detention, given the nature of the environment. Thus, prisoners with a physical disability may require a great deal of resources, including

341 PRI (2018). *Global Prison Trends 2018*. Penal Reform International and Thailand Institute of Justice, 2018. Available at: https://cdn.penalreform.org/wp-content/uploads/2018/04/PRI_Global-Prison-Trends-2018_EN_WEB.pdf

342 Hayes A.J. (2017) *Aging Inside: Older Adults in Prison*. In: Elger B., Ritter C., Stöver H. (eds) *Emerging Issues in Prison Health*. Springer, Dordrecht. Doi: https://doi.org/10.1007/978-94-017-7558-8_1

343 Carter H. and Goodwin. S (2013). Understanding Clinical Review Following a Death in Custody. *Nursing Standard* 28(12):54–59. Doi: <https://doi.org/10.7748/ns2013.11.28.12.54.e7993>

Maschi T. and Richter M. (2017). Human Rights and Dignity Behind Bars: A Reflection on Death and Dying in World Prisons. *Journal of Correctional Health Care* 23(1):76–82. Available at: <https://doi.org/10.1177/1078345816685116>

special equipment such as hearing aids, sign language interpreters and wheelchairs, as well as services such as handicapped accessible living areas, access to physiotherapy and regular health checks. Maybe their most important need is their need of personal assistance from others, which is probably most often delivered by fellow prisoners.

Foreign national prisoners

The term 'foreign national prisoner' refers to a prisoner who does not carry the passport of the country in which he/she is imprisoned. Foreign national prisoners are overrepresented in places of detention worldwide. They are often disadvantaged in the criminal justice system due to increasingly punitive measures applied to foreign national offenders, discrimination, limited awareness of legal rights, lack of access to legal counselling, lack of social networks and economic marginalization.³⁴⁴

Foreign national prisoners may have diseases which are common in their country of origin but rare in the country of imprisonment and therefore may have special needs in terms of treatment. A foreign national has the right to access health care services in accordance with the standards of the country where he/she serves his/her sentence. One main challenge specific for this group is communication, meaning that interpretation services are often needed during medical examinations to prevent misunderstandings and possible health complications. Likewise, interpretation services are crucial regarding information about - inter alia - health education, and prison laws and regulations (cf. Mandela Rule 54).

Ethnic and religious minorities

A prisoner belonging to an ethnic and/or religious minority refers to a prisoner who has a different ethnic and/or religious background than the majority of people in the country of his/her imprisonment. In many countries, ethnic and religious minorities are overrepresented in places of detention. Such minority groups may, often similar to foreign national prisoners, be subject to discrimination, stigmatization, violence, exploitation and even torture by staff and/or other prisoners in the closed environment of a prison setting. They may also have decreased access to the services and programmes available within the prison. They are likely to have received inadequate health care prior to their imprisonment which makes them at higher risk of certain health conditions, including both communicable and non-communicable diseases.³⁴⁵ Ethnic and religious minorities may thus have special needs when it comes to the provision of treatment and medication, as well as often a need for interpretation services.

LGBTI prisoners

LGBTI refers to lesbian, gay, bisexual, transgender and intersex. The term lesbian refers to females with a same-sex sexual orientation, while the term gay refers to all persons with a same-sex sexual orientation, although it is usually used to refer to males. The term bisexual refers to individuals who may feel attraction to and sexual interest in other individuals of both their own and the opposite sex. The term transgender refers to having transitioned one's sexual identity from one gender to another and does not imply any specific form of sexual orientation. It is an umbrella term which is often used to describe a wide range of identities and experiences, including female to male transsexuals, male to female transsexuals, cross-dressers and many

344 UNODC (2009). *Handbook on Prisoners with Special Needs*. United Nations Office on Drugs and Crime, New York, 2009. Available at: https://www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf

345 UNODC (2009). *Handbook on Prisoners with Special Needs*. United Nations Office on Drugs and Crime, New York, 2009. Available at: https://www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf

more.³⁴⁶ Intersex people are individuals born with any of several variations in sex characteristics, including chromosomes, gonads, sex hormones or genitals that 'do not fit the typical definitions for male or female bodies'.³⁴⁷

LGBTI prisoners are a minority in the prison population with specific needs. These needs include foremost the need for protection (see under relevance to preventive monitoring), as well as often increased health care needs (especially for transgender and intersex prisoners). Some studies have shown that non-heterosexual and transgender prisoners are at increased risk of sexual assault and coercion. For instance, a literature review on transgender and incarceration in the USA in 2013 showed that the risk of being targeted for assault is substantially higher for transgender prisoners.³⁴⁸ A study in Australia in 2014 showed that non-heterosexual men were significantly more likely to have experienced sexual coercion in prison than heterosexual men.³⁴⁹ Overall however, although clearly arguing that LGBTI persons face discrimination and ill-treatment in places of detention, the quality and generalizability of existing quantitative research is often limited.

Relevance to preventive monitoring

The failure of prison authorities to address the special needs of certain prisoners, i.e. to provide them with adequate support and treatment, may amount to inhuman or degrading treatment.

In order to provide adequate support, prison authorities must for instance ensure access to protection measures, mental health support and interpretation services, as well as ensure separation of minors from adults and accessible living areas for prisoners whose mobility is impaired. In order to provide adequate treatment, prison authorities must ensure access to the medication and health checks necessary to specific vulnerable groups, as well as to special equipment such as hearing aids and wheel-chairs. Lack of provision of treatment and support may amount to ill-treatment.

The European Court of Human Rights has received many cases relating to a lack of access to care and/or unsuitable living conditions for prisoners with special needs, and most of them were found to be violations of article 3 of the European Convention on Human Rights ('No one shall be subjected to torture or to inhuman or degrading treatment or punishment'). The following is an example of prisoner in need of means to compensate for his serious physical disability. The case was judged by the Court as a violation of article 3:

Vincent v. France 24 October 2006. The applicant was serving a ten-year prison sentence imposed in 2005. Paraplegic since an accident in 1989, he is autonomous, but cannot move around without the aid of a wheelchair. He complained in particular that the conditions in which he was detained in different prisons were not adapted to his disability.

The Court held that there had been a violation of Article 3 (prohibition of degrading treatment) of the Convention on account of the fact that it had been impossible for the applicant, who is a

346 UNODC (2009). *Handbook on Prisoners with Special Needs*. United Nations Office on Drugs and Crime, New York, 2009. Available at: https://www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf

347 UNOHRC (2016). *Free & Equal Campaign Fact Sheet: Intersex*. United Nations Office of the High Commissioner for Human Rights, 2015. Available at: https://web.archive.org/web/20160304071043/https://unfe.org/system/unfe-65-Intersex_Fact-sheet_ENGLISH.pdf

348 Glezer, McNiel & Binder (2013). Transgendered and Incarcerated: A review of the Literature, Current Politics and Laws, and Ethics. *The journal of the American Academy of Psychiatry and the Law* 41(4):551-559 · December 2013. Available at: <https://pdfs.semanticscholar.org/fd25/07636c06b67325097a58165447913b37f593.pdf>

349 Simpson et al (2014). Factors Associated with Sexual Coercion in a Representative Sample of Men in Australian prisons. *Arch Sex Behav.* 2016 Jul;45(5):1195-205. doi: 10.1007/s10508-015-0653-7 (abstract only).

*paraplegic, to move autonomously around Fresnes Prison, which was particularly unsuited to the imprisonment of persons with a physical handicap who could move about only in a wheelchair.*³⁵⁰

Sometimes, for safety reasons, LGBTI prisoners are placed in isolation, segregation or 'protective custody'. During such custody, prisoners may be prevented from participating in treatment, education and job-training programs, from having contact with others, or even from leaving their cells.³⁵¹ Consequently, such 'protective custody' can have harmful physical and psychological impacts. The following case exemplifies how isolation of prisoners due to their sexual orientation, often justified as a protective measure, in fact amounts to discriminatory, inhuman and degrading treatment.³⁵²

X. v. Turkey (no. 24626/09) 9 October 2012. This case concerned a homosexual prisoner who, after complaining about acts of intimidation and bullying by his fellow inmates, was placed in solitary confinement for over 8 months in total.

*The Court took the view that these detention conditions had caused the applicant mental and physical suffering, together with a feeling that he had been stripped of his dignity, thus representing "inhuman or degrading treatment" in breach of Article 3 of the Convention. The Court further found that the main reason for the applicant's solitary confinement had not been his protection but rather his sexual orientation. It thus concluded that there also had been discriminatory treatment in breach of Article 14 (prohibition of discrimination) of the Convention.*³⁵³

Discriminatory treatment of LGBTI persons is magnified in places of detention, in which LGBTI prisoners are frequently subjected to discrimination, stigmatization, harassment, violence and torture.³⁵⁴ Compared to other prisoners, LGBTI persons report the highest rate of sexual victimization, including rape, and consequently are at high risk of acquiring sexually transmitted diseases such as HIV/AIDS.³⁵⁵ A survey across prisons in the US has documented that 12% of prisoners who identified their sexual orientation as gay, lesbian, bisexual, or other, reported being sexually victimized by another inmate, while 5.4% reported being sexually victimized by prison staff members. The rates of sexual victimization were substantially higher than those of prisoners who identified their sexual orientation as heterosexual. For instance, rates of sexual victimization by other prisoners against non-heterosexual prisoners were at least 10 times greater than that of heterosexual prisoners when the victim was also male, black, Hispanic, or had less than a high school education. These differences were smaller, but still large, among non-heterosexual female prisoners (2.5 times larger), whites (more than 6 times larger), and high school graduates

350 ECHR (2019). *Factsheet – Prisoners' health-related rights*. European Court of Human Rights, February 2019. Available at: http://www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf

351 Metzner and Fellner (2010). Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics. *The Journal of the American Academy of Psychiatry and the Law* 38(1):104–8. Available at: <http://jaapl.org/content/jaapl/38/1/104.full.pdf>

352 ECHR (2018). *Factsheet – Sexual Orientation Issues: 9 October 2012, X. v. Turkey (No. 24626/09)*. European Court on Human Rights, 2018. Available at: https://www.echr.coe.int/documents/fs_sexual_orientation_eng.pdf

353 ECHR (2020). *Factsheet - Detention conditions and treatment of prisoners*. European Court of Human Rights, May 2020. Available at: https://www.echr.coe.int/Documents/FS_Detention_conditions_ENG.pdf

354 APT (2018). *Towards the Effective Protection of LGBTI Persons Deprived of Liberty: A Monitoring Guide*. Association for the Prevention of Torture, Geneva. Available at: https://apt.ch/content/files_res/apt_20181204_towards-the-effective-protection-of-lgbti-persons-deprived-of-liberty-a-monitoring-guide-final.pdf

PRI (2018). *Global Prison Trends 2018*. Penal Reform International and Thailand Institute of Justice, 2018. Available at: https://cdn.penalreform.org/wp-content/uploads/2018/04/PRI_Global-Prison-Trends-2018_EN_WEB.pdf

355 APT (2018). *Towards the Effective Protection of LGBTI Persons Deprived of Liberty: A Monitoring Guide*. Association for the Prevention of Torture, Geneva. Available at: https://apt.ch/content/files_res/apt_20181204_towards-the-effective-protection-of-lgbti-persons-deprived-of-liberty-a-monitoring-guide-final.pdf

(8 times larger). Victimization rates by staff members were at least double for non-heterosexual prisoners compared to heterosexual prisoners.³⁵⁶

LGBTI prisoners are often in need of protection, and moreover in need of mental health support associated with their victimization. Furthermore, transgender prisoners may have a special need for hormonal treatment. However, many do not receive the hormonal medical treatment that they used to receive prior to imprisonment due to restrictive and gender-insensitive health care policies or health care staff being unaware of, or untrained in, how to address these specific needs.³⁵⁷

International standards and guidance

Prison authorities have a responsibility in protecting the health and safety of the prison population, and in ensuring that all prisoners have the opportunity to live an as healthy life as possible within the setting they are in. Such responsibility implies that prison authorities must address the special needs of vulnerable prisoners, to an extent that complies with international standards and the standards in the general society in the country.

The Mandela Rules include rules specifically addressing vulnerable prisoners with special needs. It is outlined in Rule 2 that *'the rules shall be applied impartially. There shall be no discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or any other status. The religious beliefs and moral precepts of prisoners shall be respected'* (2.1.). And that: *'in order for the principle of non-discrimination to be put into practice, prison administrations shall take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings. Measures to protect and promote the rights of prisoners with special needs are required and shall not be regarded as discriminatory'* (2.2.).

Moreover, in Rule 5.2, the Mandela Rules outline that *'prison administrations shall make all reasonable accommodation and adjustments to ensure that prisoners with physical, mental or other disabilities have full and effective access to prison life on an equitable basis'*.

International standards and guidance specific to minor prisoners

The Mandela Rules outline in Rule 11 that *'young prisoners shall be kept separate from adults.'*

Besides the Mandela Rules, the UN Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules)³⁵⁸, and the UN Rules for the Protection of Juveniles Deprived of their Liberty³⁵⁹ are essential when monitoring places of detention where minors are kept. These rules establish the minimum standards accepted by the UN for the protection and treatment of juvenile prisoners and offenders.

Defense for Children International (DCI), an independent non-governmental organization based in Geneva, has published a practical guide on monitoring places where children are deprived of liberty³⁶⁰, which is a very useful guide when monitoring places of detention where minors are kept.

356 U.S. Department of Justice (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: National Inmate Survey, 2011–12*. Available at: <https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf>

357 White Hughto et al. (2018). Creating, Reinforcing, and Resisting the Gender Binary: A Qualitative Study of Transgender Women's Healthcare Experiences in Sex-Segregated Jails and Prisons. *International Journal of Prisoner Health* 14(2):69–88. Available for download at: https://www.researchgate.net/publication/318707730_Creating_reinforcing_and_resisting_the_gender_binary_A_qualitative_study_of_transgender_women's_healthcare_experiences_in_sex-segregated_jails_and_prisons

358 UN (1985). *United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules)*. United Nations, 1985. Available at: <https://www.ohchr.org/documents/professionalinterest/beijingrules.pdf>

359 UN (1990). *UN Rules for the Protection of Juveniles Deprived of Their Liberty*. United Nations, 1990. Available at: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/JuvenilesDeprivedOfLiberty.aspx>

360 DCI (2016). *Practical guide, monitoring places where children are deprived of their liberty*. Defence for Children International, Belgium, 2016. Available at: <https://defenceforchildren.org/wp-content/uploads/2016/02/DCI-Practical-GuideEN.pdf>

International standards and guidance specific to prisoners with physical disabilities, including those of advanced age

The Mandela Rules include in Rule 5 that *'prison administrations shall make all reasonable accommodation and adjustments to ensure that prisoners with physical, mental or other disabilities have full and effective access to prison life on an equitable basis.'*

The CPT standards elaborate on this in standard number 38:

'A prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community. Provision in terms of medical, nursing and technical staff, as well as premises, installations and equipment, should be geared accordingly.'

The UN Convention on the Rights of Persons with Disabilities from 2008³⁶¹ includes clear obligations to States with regard to the treatment and care of prisoners with disabilities. The Convention defines persons with disabilities as *'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'* and outlines the following general principles which should be adhered to:

- a. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- b. Non-discrimination;
- c. Full and effective participation and inclusion in society;
- d. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- e. Equality of opportunity;
- f. Accessibility;
- g. Equality between men and women;
- h. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

The Convention clearly addresses equality and non-discrimination and includes paragraphs on for instance participation and inclusion, personal mobility, and the promotion of training of professionals and staff members working with persons with disabilities, which are equally relevant in prison settings as they are in the outside community.

International standards and guidance specific to foreign national prisoners

The Mandela Rules state in Rule 55 that information for the prisoners *'shall be available in the most commonly used languages in accordance with the needs of the prison population. If a prisoner does not understand any of those languages, interpretation assistance should be provided.'*

Mandela Rule 62 states that *'prisoners who are foreign nationals shall be allowed reasonable facilities to communicate with the diplomatic and consular representatives of the State to which they belong'* and that *'prisoners who are nationals of States without diplomatic or consular representation in the country and refugees or stateless persons shall be allowed similar facilities to communicate*

³⁶¹ UN (2008). *Convention on the Rights of persons with Disabilities*. United Nations. Available at: <https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

with the diplomatic representative of the State which takes charge of their interests or any national or international authority whose task it is to protect such persons.'

International standards and guidance specific to religious minorities in prison settings

The Mandela Rules state in Rule 66 that *'so far as practicable, every prisoner shall be allowed to satisfy the needs of his or her religious life by attending the services provided in the prison and having in his or her possession the books of religious observance and instruction of his or her denomination.'*

International standards specific to LGBTI prisoners

The relevant international standards relating to the treatment of LGBTI persons in places of detention are summarized in the Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity.³⁶² The Yogyakarta Principles is a soft law document, which was published as the outcome of an international meeting of human rights experts and groups in Yogyakarta, Indonesia, in November 2006. The principles have not been adopted by States and are thus not by themselves a legally binding part of international human rights law. However, they serve as an interpretative aid to human right treaties. In 2017, the following key additions to the Principles were outlined relating to the right to treatment with humanity while in detention:

States shall:

- *Adopt and implement policies to combat violence, discrimination and other harm on grounds of sexual orientation, gender identity, gender expression or sex characteristics faced by persons who are deprived of their liberty, including with respect to such issues as placement, body or other searches, items to express gender, access to and continuation of gender affirming treatment and medical care, and "protective" solitary confinement;*
- *Adopt and implement policies on placement and treatment of persons who are deprived of their liberty that reflect the needs and rights of persons of all sexual orientations, gender identities, gender expressions, and sex characteristics and ensure that persons are able to participate in decisions regarding the facilities in which they are placed;*
- *Provide for effective oversight of detention facilities, both with regard to public and private custodial care, with a view to ensuring the safety and security of all persons, and addressing the specific vulnerabilities associated with sexual orientation, gender identity, gender expression and sex characteristics.*

In conclusion, prison authorities should address the special needs that vulnerable groups in places of detention have and moreover, have in view the prevention of discrimination, stigmatization, harassment, exploitation, violence, ill-treatment and torture of these groups. The protection and support available to them must be facilitated in such way that harmful consequences, such as by isolation, are avoided. In general, prison authorities should ensure that all prisoners have the possibility to carry out daily basic activities and participate in ordinary prison life on an equitable basis.

Monitoring methodology

The monitor should be aware of the rights and special needs that specific vulnerable groups have and assess to what extent the prison administration meets these rights and special needs, i.e. the institution's compliance with national and international standards, as well as assess how needs of prisoners belonging to these groups are met in practice, in terms of possible ill-treatment.

362 Anon (2017). *The Yogyakarta Principles plus 10*. Available at: <https://yogyakartaprinciples.org/principles-en/>

During the monitoring visit, the monitor may aim to select prisoners for interviews based on their gender, age, nationality, ethnicity, religion, or physical disability in case this can be done by observation or in case this is ethically acceptable. In case of a thematic monitoring visit looking into a specific area (such as religion or physical disabilities), this could be communicated to the prisoners in advance so that those who are willing to talk to the monitoring team could come forward.

Interviews with prisoners should always be conducted in the safest and most respectful conditions for the prisoners and without the risk of them facing reprisals, by staff members or fellow prisoners. The monitor should make all efforts possible in order for the prisoners to feel confident, safe and secure in talking to him or her. It is highly recommended that a monitor interviewing juveniles has experience in working with children, child and welfare issues, and juvenile justice.

The monitor should ask the prison management about the general policies and practices in the institution, referring to vulnerable groups with special needs. Questions could include which of the vulnerable groups with special needs are represented in the institution, what the main challenges are with each of these groups, and where and how they are accommodated in the institution.

Interviews with prisoners should focus on getting information on how they experience life in prison and the daily activities and the treatment and support available to them. It should be attempted to select both prisoners not belonging to a vulnerable group and prisoners belonging to a vulnerable group for the interviews. Questions that could be asked include whether or not the person has experienced discrimination, stigmatization, harassment, abuse and/or violence by fellow prisoners and/or by prison staff, and whether prisoners' special needs (related to protection, treatment or support) are being adhered to by the institution.

Interviews with prison health staff should foremost concentrate on their role in identifying vulnerable groups and assessing their special needs (e.g. when conducting the initial medical assessment), on the availability of special treatments and care for the different vulnerable groups, and on whether prison health staff has received targeted training on providing health care to these vulnerable groups with special needs.

Interviews with prison guards should concentrate on getting more information on the daily prison life of the different vulnerable groups. This could for instance include questions on accommodation, participation in activities, exposure to discrimination, abuse, harassment, violence, exploitation and/or stigmatization.

During the entire monitoring visit, the health monitor should use his/her observational skills to get more information on how vulnerable groups with special needs are living and coping in the institution. Observations should for instance include an assessment of the accommodation of these groups (in terms of their location and suitability) and an assessment of whether certain groups are segregated at all times (e.g. minors from adults).

The final information source which the health monitor should use during the monitoring visit are documents, including any written instructions, registers and medical records that can be accessed. It will for instance provide useful information to look into the medical record of a transgender prisoner, to see whether he/she has been given any hormonal treatment in case he/she requested this.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

Anon (2017). *The Yogyakarta Principles plus 10*. Available at: <https://yogyakartaprinciples.org/principles-en/>

APT (2018). *Towards the Effective Protection of LGBTI Persons Deprived of Liberty: A Monitoring Guide*. Association for the Prevention of Torture, Geneva. Available at: https://apt.ch/content/files_res/apt_20181204_towards-the-effective-protection-of-lgbti-persons-deprived-of-liberty-a-monitoring-guide-final.pdf

CPT (2010). *CPT Standards 2002, revision 2010*. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2010. Available at: <https://www.refworld.org/pdfid/4d7882092.pdf>

DCI (2016). *Children's Rights behind Bars: Human Rights of Children Deprived of Liberty; Improving Monitoring Mechanisms*. Defence for Children International, Belgium, 2016. Available at: <https://defenceforchildren.org/wp-content/uploads/2015/07/Childrens-right-Behind-Bars-A-European-Overview.pdf>

DCI (2016). *Practical guide, monitoring places where children are deprived of their liberty*. Defence for Children International, Belgium, 2016. Available at: <https://defenceforchildren.org/wp-content/uploads/2016/02/DCI-Practical-GuideEN.pdf>

OSCE & PRI (2018). *Guidance Document on the Nelson Mandela Rules: Implementing the United Nations Revised Standard Minimum Rules for the Treatment of Prisoners*. OSCE Office for Democratic Institutions and Human Rights and Penal Reform International. 2018. Available at: https://cdn.penalreform.org/wp-content/uploads/2018/07/MR_Guidance_Doc.pdf

UN (1985). *United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules)*. United Nations, 1985. Available at: <https://www.ohchr.org/documents/professionalinterest/beijingrules.pdf>

UN (1990). *UN Rules for the Protection of Juveniles Deprived of Their Liberty*. United Nations, 1990. Available at: <https://www.ohchr.org/EN/ProfessionalInterest/Pages/JuvenilesDeprivedOfLiberty.aspx>

UN (2008). *Convention on the Rights of persons with Disabilities*. United Nations. Available at: <https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UNODC (2009). *Handbook on Prisoners with Special Needs*. United Nations Office on Drugs and Crime, New York, 2009. Available at: https://www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Copenhagen, Denmark. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf?ua=1

5.9. Specific needs of female prisoners and accompanying children

More than 700,000 women and girls are held in penal institutions throughout the world. They constitute only a small minority of prison populations, generally between 2% and 9% of the total prison population in a country. Although the proportion of women out of the total prison population is low, female prison population levels have risen sharply over the last years and at a higher rate than male prison population levels.³⁶³ Prisons have generally been built by and for men, with little consideration given to the impact of prison designs, policies and regimes on women. The specific needs of women are often overlooked in various areas, including healthcare, security procedures, family contact, and opportunities for work.³⁶⁴

In general, female prisoners have more and different health needs than male prisoners. These include a need for gender-sensitive and gender-specific care, including the need for reproductive health care. Women's needs include for instance accessibility to more regular showers and personal care products during menstruation, and the need for sanitary napkins and the like free of charge. It is too often seen that women's normal human functions, such as menstruation, are being medicalized in a prison setting, for example, prison guards or prison health staff having the power to approve or manage access to sanitary napkins.³⁶⁵

Research shows that the mental health needs of women prisoners around the world are distinct, and that overall, compared to male prisoners, female prisoners have a higher rate of psychiatric disorders, PTSD, and drug dependence problems. Also, the prevalence of HIV and other infectious diseases is often higher among women prisoners and they are more likely to engage in self-harming and to commit suicide than male prisoners.³⁶⁶

Many women in prison are mothers and usually the primary or sole care-taker for their children. In many countries, children born to women in prison can stay in prison with their mother, and very young children may accompany their mothers into prison. In such cases, the needs of the children must always be put first when it comes to decisions about the length of their stay in the place of detention.³⁶⁷ The age up to which a child can stay with the mother in prison varies widely between and within countries – from one year old up to six years old³⁶⁸ – and so do the facilities for them to stay with their mother. Unfortunately, facilities and environments are often sub-optimal and not resembling those of children outside of prison. In some countries, e.g. Cameroon, pregnant women, nursing mothers and their children are admitted to prison even

363 Walmsley (2017). *World Female Imprisonment List*. World Prison Brief, Institute for Criminal Policy Research, University of London, Fourth edition, 2017. Available at: http://www.prisonstudies.org/sites/default/files/resources/downloads/world_female_imprisonment_list_third_edition_0.pdf

364 WHO/Europe & UNODC (2009). *Women's health in prison: Correcting gender inequity in prison health*. World Health Organization Regional Office for Europe & United Nations Office on Drugs and Crime, 2009. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf

Van den Bergh et al (2011). Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. *Bulletin of the World Health Organization*, 89(9), 689–694. Available at: <https://doi.org/10.2471/BLT.10.082842>

Van Kempen and Krabbe (& UN) (2017). *Women in Prison: A Transnational Perspective. Women in prison: the Bangkok Rules and beyond*. Available at: <http://www.epea.org/wp-content/uploads/Women-in-prison-Bangkok-rules-and-beyond.pdf>

365 WHO/Europe & UNODC (2009). *Women's health in prison: Correcting gender inequity in prison health*. World Health Organization Regional Office for Europe & United Nations Office on Drugs and Crime, 2009. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf

366 Van den Bergh et al (2011). Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. *Bulletin of the World Health Organization*, 89(9), 689–694. Available at: <https://doi.org/10.2471/BLT.10.082842>

367 WHO/Europe & UNODC (2009). *Women's health in prison: Correcting gender inequity in prison health*. World Health Organization Regional Office for Europe & United Nations Office on Drugs and Crime, 2009. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf

368 WHO/Europe & UNODC (2009). *Women's health in prison: Correcting gender inequity in prison health*. World Health Organization Regional Office for Europe & United Nations Office on Drugs and Crime, 2009. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf

though the countries' penal codes do not allow for this. Consequently, there are no facilities to address the needs of these women and their children.³⁶⁹

There is a lot of discussion about whether or not it is in the best interest of a child to stay in prison with his/her mother and this of course depends on many factors, including the (mental) health status of the mother, the availability of adequate care outside of prison provided by the father or another family member, and the facilities and daily activities available to the child in prison.

Research shows that, although causal mechanisms are unclear, children of prisoners are twice as likely to have mental health issues than children without imprisoned parents.³⁷⁰ This refers to all children, regardless of them staying in prison with their mother or staying with other caretakers in the community. When staying in prison, residing in poor facilities and not having access to adequate care may in fact aggravate their situation.

Relevance to preventive monitoring

The failure of prison authorities to address the specific needs of women and their children in their institutions may amount to inhuman and degrading treatment. Examples include a woman who needs to undergo a gynecological exam by a male doctor while this is in violation with her religion. Also, a lack of access to reproductive health care in general and poor nutrition for pregnant women could certainly amount to ill-treatment. Examples concerning ill-treatment of accompanying children include children not being able to every day spend some time in the fresh air outside and children's mental health issues not being addressed and followed-up on.

In order to address the needs of women (and their accompanying children) in places of detention, prison authorities must ensure that prison staff carries out adequate security procedures that take into account the protection from physical and psychological violence and abuse. Violence in places of detention where females are kept, occurs among women themselves as well as against women by men and may include physical, psychological and sexual violence, including sexual harassment, rape and abuse.³⁷¹

In 2014, DIGNITY conducted a study on women in detention in five countries (Albania, Guatemala, Jordan, the Philippines and Zambia), which showed some examples of conditions and treatments of pregnant women in violation with international standards:

"DIGNITY spoke with women who were detained during the last stages of pregnancy. All suffered harmful levels of anxiety. In one case, an inmate in the Philippines chose to give birth in an ill-equipped jail clinic because she did not fully understand her options. Another woman, eight months pregnant, told DIGNITY that her medical records were not accessed, and her doctor's information was never taken, although she gave birth while detained. As noted, shackles are still sometimes used on women during labour in the Philippines – an unacceptable practice that causes extreme discomfort and anxiety, and violates international standards".³⁷²

369 Linonge-Fontebo & Rabe (2015). Mothers in Cameroonian Prisons: Pregnancy, Childbearing and Caring for Young Children. *African Studies*, 74(3), 290–309. Available at: <https://doi.org/10.1080/00020184.2015.1068000>

370 Murray et al. (2009). *Effects of parental imprisonment on child antisocial behaviour and mental health: a systematic review*. *Campbell Syst Rev*, 4 (2009). Available at: <https://www.ncjrs.gov/pdffiles1/nij/grants/229378.pdf>

371 Van Hout & Mhlanga-Gunda (2018). Contemporary women prisoners health experiences, unique prison health care needs and health care outcomes in sub Saharan Africa: a scoping review of extant literature. *BMC International Health and Human Rights*, 18(1). Available at: <https://doi.org/10.1186/s12914-018-0170-6>

372 DIGNITY (2014). *Conditions for women in detention: needs, vulnerabilities and good practices*. DIGNITY - Danish Institute against Torture, Copenhagen, 2014. Available at: https://dignity.dk/wp-content/uploads/publication_series_no7.pdf

Another example of a violation of a woman's human rights concerns virginity testing. Virginity testing is discriminatory, humiliating and causes pain and suffering. It is an intrusion of a woman's privacy and it may be considered a form of cruel, inhuman or degrading treatment or even torture or rape.³⁷³

International standards and guidance

The Mandela Rules include a few rules (11a, 28 and 29) which are of particular relevance when monitoring places of detention for women. They state that prison authorities need to ensure separate accommodation for men and women. Special accommodation needs to be in place for prenatal and postnatal care and treatment. Female prisoners should give birth in a hospital outside the prison and in case a child is born in the prison anyhow, this shall not be mentioned in his/her birth certificate. With regard to children of prisoners, it is stated that a decision on whether the child should be allowed to stay with his/her parent in prison (usually the mother) shall be based on the best interest of the child and that in case children are allowed to stay with their parent in prison, special provisions shall be made.

In December 2010, the UN General Assembly adopted the Bangkok Rules, i.e. the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, published in 2011.³⁷⁴ The Bangkok Rules consist of 70 Rules taking into account the specific characteristics and needs of women offenders and prisoners and are, in addition to the Mandela Rules, the key reference when monitoring places of detention where women (and their children) are kept.

The following of the Bangkok Rules are especially relevant when monitoring issues related to the health of female prisoners – and their accompanying children - and the treatment and support available to them:

5. Personal hygiene

Rule 5

The accommodation of women prisoners shall have facilities and materials required to meet women's specific hygiene needs, including sanitary towels provided free of charge and a regular supply of water to be made available for the personal care of children and women, in particular women involved in cooking and those who are pregnant, breastfeeding or menstruating.

6. Health care services

(a) Medical screening on entry

Rule 6

The health screening of women prisoners shall include comprehensive screening to determine primary healthcare needs, and also shall determine:

- (a) The presence of sexually transmitted diseases or blood-borne diseases; and, depending on risk factors, women prisoners may also be offered testing for HIV, with pre- and post-test counselling;*
- (b) Mental health-care needs, including post-traumatic stress disorder and risk of suicide and self-harm;*

³⁷³ Independent Forensic Expert Group (2015). Statement on virginity testing. *Journal of Forensic and Legal Medicine* Volume 33, July 2015, Pages 121-124. Available at: <https://doi.org/10.1016/j.jflm.2015.02.012>

³⁷⁴ UN (2011). *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)*. United Nations, New York, 2011. Available at: https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf

- (c) *The reproductive health history of the woman prisoner, including current or recent pregnancies, childbirth and any related reproductive health issues;*
- (d) *The existence of drug dependency;*
- (e) *Sexual abuse and other forms of violence that may have been suffered prior to admission.*

Rule 7

- 1. If the existence of sexual abuse or other forms of violence before or during detention is diagnosed, the woman prisoner shall be informed of her right to seek recourse from judicial authorities. The woman prisoner should be fully informed of the procedures and steps involved. If the woman prisoner agrees to take legal action, appropriate staff shall be informed and immediately refer the case to the competent authority for investigation. Prison authorities shall help such women to access legal assistance.*
- 2. Whether or not the woman chooses to take legal action, prison authorities shall endeavour to ensure that she has immediate access to specialized psychological support or counselling.*
- 3. Specific measures shall be developed to avoid any form of retaliation against those making such reports or taking legal action.*

Rule 8

The right of women prisoners to medical confidentiality, including specifically the right not to share information and not to undergo screening in relation to their reproductive health history, shall be respected at all times.

Rule 9

If the woman prisoner is accompanied by a child, that child shall also undergo health screening, preferably by a child health specialist, to determine any treatment and medical needs. Suitable health care, at least equivalent to that in the community, shall be provided.

(b) Gender-specific health care

Rule 10

- 1. Gender-specific health-care services at least equivalent to those available in the community shall be provided to women prisoners.*
- 2. If a woman prisoner requests that she be examined or treated by a woman physician or nurse, a woman physician or nurse shall be made available, to the extent possible, except for situations requiring urgent medical intervention. If a male medical practitioner undertakes the examination contrary to the wishes of the woman prisoner, a woman staff member shall be present during the examination.*

Rule 11

- 1. Only medical staff shall be present during medical examinations unless the doctor is of the view that exceptional circumstances exist or the doctor requests a member of the prison staff to be present for security reasons or the woman prisoner specifically requests the presence of a member of staff as indicated in rule 10, paragraph 2, above.*
- 2. If it is necessary for non-medical prison staff to be present during medical examinations, such staff should be women and examinations shall be carried out in a manner that safeguards privacy, dignity and confidentiality.*

(c) Mental health and care

Rule 12

Individualized, gender-sensitive, trauma-informed and comprehensive mental health care and rehabilitation programmes shall be made available for women prisoners with mental health-care needs in prison or in noncustodial settings.

Rule 13

Prison staff shall be made aware of times when women may feel particular distress, so as to be sensitive to their situation and ensure that the women are provided appropriate support.

(d) HIV prevention, treatment, care and support

Rule 14

In developing responses to HIV/AIDS in penal institutions, programmes and services shall be responsive to the specific needs of women, including prevention of mother-to-child transmission. In this context, prison authorities shall encourage and support the development of initiatives on HIV prevention, treatment and care, such as peer-based education.

(e) Substance abuse treatment programmes

Rule 15

Prison health services shall provide or facilitate specialized treatment programmes designed for women substance abusers, taking into account prior victimization, the special needs of pregnant women and women with children, as well as their diverse cultural backgrounds.

(f) Suicide and self-harm prevention

Rule 16

Developing and implementing strategies, in consultation with mental health-care and social welfare services, to prevent suicide and self-harm among women prisoners and providing appropriate, gender-specific and specialized support to those at risk shall be part of a comprehensive policy of mental health care in women's prisons.

(g) Preventive health-care services

Rule 17

Women prisoners shall receive education and information about preventive health-care measures, including on HIV, sexually transmitted diseases and other blood-borne diseases, as well as gender-specific health conditions.

Rule 18

Preventive health-care measures of particular relevance to women, such as Papanicolaou tests and screening for breast and gynaecological cancer, shall be offered to women prisoners on an equal basis with women of the same age in the community.

The Bangkok Rules also include rules specifically addressing children who accompany their mother in prison and their separation. In addition to what is included in the Mandela Rules, it is stated that women prisoners whose children are in prison with them shall be provided with the maximum possible opportunities to spend time with their children. Moreover, Rules 51 and 52 state that:

Rule 51

1. *Children living with their mothers in prison shall be provided with ongoing health-care services and their development shall be monitored by specialists, in collaboration with community health services.*
2. *The environment provided for such children's upbringing shall be as close as possible to that of a child outside prison.*

Rule 52

1. *Decisions as to when a child is to be separated from its mother shall be based on individual assessments and the best interests of the child within the scope of relevant national laws.*
2. *The removal of the child from prison shall be undertaken with sensitivity, only when alternative care arrangements for the child have been identified and, in the case of foreign-national prisoners, in consultation with consular officials.*
3. *After children are separated from their mothers and placed with family or relatives or in other alternative care, women prisoners shall be given the maximum possible opportunity and facilities to meet with their children, when it is in the best interests of the children and when public safety is not compromised.*

Monitoring methodology

A monitor should be familiar with the rights and specific needs that women – and their accompanying children – have within a place of detention and assess to what extent the prison administration meets these rights and needs, i.e. the institution's compliance with national and international standards.

Following a Declaration on Women's health in Prison in 2009³⁷⁵, the WHO Regional Office for Europe and the United Nations Office on Drugs and Crime jointly issued a publication in 2011 including action guidance and checklists on women's health in prison, to review policies and practices.³⁷⁶ The publication is a very useful tool when monitoring places of detention for women, outlining the different aspects to investigate when assessing their health and the health care services available to them. It includes questions to address specifically to prison management and prison health staff.

During the monitoring visit, the monitor should ask the prison management about the general policies and practices in the institution, including specific health-related provisions and programmes available for women. Questions could for instance include how the gender balance among the staff working with female prisoners is, whether women have access to a female doctor, and whether gender-sensitivity trainings are available to staff members. The management could also be asked about any cases of sexual violence and abuse (both staff-prisoner and prisoner-prisoner).

Interviews with female prisoners should focus on getting information on their daily life in prison and on whether their specific needs are being met by the prison administration and the prison health services. Questions could for instance include a focus on their accommodation, daily activities, and access to gender-sensitive and gender-specific health care. The women could also be asked about their interaction with male prison staff and whether they experience this interaction

375 WHO/Europe & UNODC (2009). *Women's health in prison: Correcting gender inequity in prison health*. World Health Organization Regional Office for Europe & United Nations Office on Drugs and Crime, 2009. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf

376 WHO/Europe & UNODC (2011). *Women's health in prison: action guidance and checklists to review current policies and practices*. World Health Organization Regional Office for Europe & United Nations Office on Drugs and Crime, 2011. Available at: https://www.unodc.org/documents/hiv-aids/WHO_UNODC_2011_Checklist_Womens_health_in_prison.pdf

as respectful. In case a woman is being accompanied by her child in the institution, questions should include a focus on the facilities, activities and health care available to the child.

Interviews with prison health staff should foremost focus on the availability and accessibility of gender-sensitive and gender-specific health care. Reproductive health care should clearly be included in the focus, for instance asking about the women's access to a gynecologist as well as facilities and specific health care services available to pregnant and breastfeeding women.

Interviews with prison guards should foremost concentrate on getting more information on the daily life of the female prisoners, including accommodation, access to showers, access to sanitary napkins and specific facilities for pregnant and breastfeeding women.

The monitor should use his/her observational skills during the entire monitoring visit, observing the accommodation, living areas and facilities where the women reside.

Looking into available documents during the monitoring visit, will give additional information on the way the institution deals with the gender-specific needs of women in prison. Medical records are likely to give useful information with regard to access to gender-specific health care, including reproductive health care and referrals to a gynecologist. When there are children residing in the institution with their mother, the medical records of the children should be checked with regard to their access to health care, regular check-ups and vaccinations.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

APT (2019). *Detention Focus: Women*. Association for the Prevention of Torture, 2019. Available at: https://apt.ch/detention-focus/en/vulnerable_groups/1/

UN(2011). *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)*. United Nations, New York, 2011. Available at: https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

WHO/Europe & UNODC (2009). *Women's health in prison: Correcting gender inequity in prison health*. World Health Organization Regional Office for Europe & United Nations Office on Drugs and Crime, 2009. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf

WHO/Europe & UNODC (2011). *Women's health in prison: action guidance and checklists to review current policies and practices*. World Health Organization Regional Office for Europe & United Nations Office on Drugs and Crime, 2011. Available at: https://www.unodc.org/documents/hiv-aids/WHO_UNODC_2011_Checklist_Womens_health_in_prison.pdf

5.10. Violence

The World Health Organization has defined violence as *'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation'*.³⁷⁷

Violence in places of detention may occur in different forms, including physical violence, psychological violence (including threats, bullying or humiliation), and sexual violence/assaults/rape. Apart from its categorization as physical, psychological and sexual violence, it could be categorized as follows:

1. Violence between prisoners (inter-prisoner violence)
2. Violence between prisoners and prison staff. This can be divided into two categories:
 - Violence from prisoners towards staff, which may even involve riots, where the staff needs to protect themselves, other prisoners and materials with necessary use of force.
 - Violence from staff towards prisoners, including ill-treatment, torture and excessive use of force.

Prisoners' self-inflicted violence equals self-harming or committing suicide and is therefore covered in the respective chapter on self-harming and suicide in this Section. This chapter focuses solely on the above two categories of violence.

Frequency of violence in places of detention

Violence (inter-prisoner violence and violence between prisoners and staff) exists in prisons globally and in high-, middle- as well as low-income countries. According to Penal Reform International's Global Prison Trends, seven prisoners were killed in the US state Alabama, 'unacceptable' rates of violence were found by the Chief Ombudsman in New Zealand prisons, and prison riots in several countries, including the Philippines, Indonesia, Nigeria, Congo and South Africa, led to the death of prisoners during 2017.³⁷⁸

Violence may be experienced by all prisoners (and prison staff), but certain groups of prisoners are at increased risk for violence by other prisoners or by staff members. These include for instance LGBTI, foreign nationals, prisoners with a mental health problem, ethnic/religious minorities as well as those who committed sexual offences.³⁷⁹ In some facilities, violence between gang rivals is a severe problem, both because of the high frequencies but also because of the severity of the violence.

As described in the WHO publication Prisons and Health, 25% of prisoners (men and women) experience violence while they are imprisoned and, in some facilities, 20% of prisoners have been exposed to staff-to-prisoner violence. Furthermore, 4-5% experience sexual violence and

377 WHO (2002). *World report on violence and health*. World Health Organization, Geneva, 2002. Available at: https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf;jsessionid=35F478A426DA61FADC2D7CA2D5E36BE1?sequence=1

378 PRI (2018). *Global Prison Trends 2018*. Penal Reform International, United Kingdom, 2018. Available at: https://cdn.penalreform.org/wp-content/uploads/2018/04/PRI_Global-Prison-Trends-2018_EN_WEB.pdf

379 WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Denmark, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf
Wolff et al (2007). Physical Violence Inside Prisons: Rates of Victimization. *Crim. Justice Behav.* 34, 588–599. Available at: <https://doi.org/10.1177/0093854806296830>

1-2% have been raped.³⁸⁰ These numbers vary between institutions, regions and countries and underreporting should be taken into consideration.

In general, male prisoners are more often exposed to both inter-prisoner violence and staff-on-prisoner violence than female prisoners. At the same time, female staff members have shown to have a violence-reducing effect in the prison setting.³⁸¹

Unpublished data from a study by DIGNITY showed that out of a total study population of 454 prisoners in five countries (Honduras, Philippines, Kosovo, Albania and Sierra Leone), 6 out of 10 prisoners reported to have experienced violence by correctional staff (either physical, psychological or sexual). About half had experienced physical violence, and more had experienced psychological violence by staff members.

Violence in places of detention is often difficult to assess precisely because it is surrounded by silence and often underreported. Violence is in most cases illegal and punishable and therefore prisoners' reporting of violence committed by other prisoners or prison staff may lead to reprisals and retaliation. This may even be more so in cases of sexual violence.

Causes of violence in places of detention

Unfortunately, violence is a frequent reality in places of detention. Housing a broad range of people with different background and personalities, many of whom have well-documented violent behavior and/or mental health problems, together in a closed environment and in often overcrowded and suboptimal conditions, makes the occurrence of violent events difficult to prevent and control.

Violence between prisoners is often related to gang rivalries, overcrowding, disputes, and prison designs contributing to conflicts. Violent attacks can be either impulsive or well-planned. They can involve psychological violence, sexual violence, beatings and attacks with self-made weapons, including homemade knives, razors etc. When many prisoners are involved in a violent event, this is referred to as a prison riot. Prison riots often get extensive media attention and are frequently related to gang rivalries (inter-prisoner violence) or it may be a reaction generated by general dissatisfaction of the prisoners with the conditions and treatment in the place of detention and directed against the staff members (prisoner-staff violence/ a rebellion).

In some prisons in developing countries, there is a severe lack of staff, and prisoners are therefore developing a hierarchy amongst themselves with some prisoners in charge of disciplining others. This often involves violent episodes, which are hard to prevent and act upon due to the lack of staff.

When violence in places of detention is related to drugs and money, corruption can play a key role. For instance, prisoners, such as gang members low in the hierarchy, can be forced to smuggle drugs and are especially vulnerable to violent episodes if they fail. Great amounts of money are in play and staff members and 'strong' prisoners are in control. Furthermore, competing gangs may fight over access to the drug market inside and outside prison and leaders may require indebted customers to pay their debt with violent means.

380 WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Denmark, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

381 WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Denmark, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf
Wolff et al (2007). Physical Violence Inside Prisons: Rates of Victimization. *Crim. Justice Behav.* 34, 588–599. Available at: <https://doi.org/10.1177/0093854806296830>

Relevance to preventive monitoring

Prison authorities have an obligation to prevent violence in places of detention whether committed by staff members or by prisoners. This includes putting in place means to decrease violence when it occurs as well as preventive means. Steps that can be taken to minimize inter-prisoner violence include for instance identifying prisoners at risk (vulnerable groups) and ensuring protective means are in place (such as avoiding joint activities³⁸²), reducing blind spots in the institution (out of sight/hearing from prison staff members and/or oversight cameras), and training prison staff members in how to prevent violence and how to act in case of a violent event. Conflicts between staff members and prisoners should be avoided by creating a sound and respectful relationship with good contact and communication. A crucial part is to handle conflicts before they escalate to violence and/or use of force (dynamic security).

Any assault on a person's dignity and physical or mental integrity comes under this obligation and may range from lack of protection to ill-treatment and torture, as illustrated by the below case. The case is described in the report *"Abuse of Detainees: Article 2 and Article 3 cases before the ECHR"* published by the Open Society Justice Foundation in 2014.³⁸³ The report presents summaries of decisions related to article 2 and article 3 made by the European Court of Human Rights.

D.F. v. Latvia (2013).

'The case concerned D.F.'s complaint that, as a former paid police informant and a sex offender, he was at constant risk of violence from his co-prisoners when held in Daugavpils prison between 2005 and 2006, and that the Latvian authorities failed to transfer him to a safer place of detention. The applicant was convicted in 2006 of rape and indecent assault on minors and sentenced to thirteen years' imprisonment. He was kept in Daugavpils Prison for over a year where he was allegedly subjected to violence by other inmates because they knew he had acted as a police informant and was a sex offender. The prison administration frequently moved him from one cell to another, exposing him to a large number of other prisoners. He made numerous applications to be moved to a special prison with a section for detainees who had worked for or collaborated with the authorities. However, his requests were repeatedly rejected because the Prisons Administration did not find it established that he had been a police informant. He was eventually transferred to the special prison.

The court held that, owing to the authorities' failure to coordinate effectively, D.F. had been exposed to the fear of imminent risk of ill-treatment for over a year, despite the authorities being aware that such a risk existed. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) had found that prisoners charged with sexual offences were exposed to a heightened risk of violence by other prisoners. It had also repeatedly expressed particular concern about such violence in Daugavpils Prison. The prison authorities had clearly been aware of the nature of the charges against the applicant and the risk they entailed. In addition, there was information within the State apparatus about the applicant's past collaboration with the police, but such information had not been systematically passed on between the relevant authorities. The Court held, unanimously, that there had been a violation of Article 3 (prohibition of inhuman and degrading treatment) of the Convention.'

The use of physical restraint measures by staff on prisoners, which could in certain cases be seen as a form of violence, is dealt with in the respective chapter in Section 4. Staff-on-prisoner violence which involves torture is dealt with in Section 6.

382 For instance, in Denmark competing gang members are accommodated in separate parts of the institution, to avoid contact and conflicts.

383 OSJI (2014). *Abuse of Detainees: Article 2 and Article 3 cases before the ECHR*. Open Society Justice Initiative, New York, 2014. Available at: <https://www.opensocietyfoundations.org/sites/default/files/briefing-ECHR-art%202-3-cases-20150505.pdf>

International standards and guidance

The UN Mandela Rules state in Rule 1 that *'all prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times.'*

Rule 2.2 touches upon the responsibility of the prison administration to protect vulnerable prisoners:

'In order for the principle of non-discrimination to be put into practice, prison administrations shall take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings. Measures to protect and promote the rights of prisoners with special needs are required and shall not be regarded as discriminatory.'

Rule 34 outlines what measures to take, if a health care provider becomes aware of signs of violence:

'If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm.'

The Association for Prevention of Torture (APT) recommends the following to limit violence between detainees, some of the points being reflected in the UN Mandela Rules as well:

- Separation of different categories
- Careful choice of detainees who share living conditions
- An easily accessible and confidential complaint system
- Sufficient numbers of trained staff
- Refraining from using prisoners in disciplinary or control roles
- Explicit and well publicized 'anti-bullying' policies.³⁸⁴

For the protection of vulnerable prisoners, the prison administration must carefully classify prisoners and keep vulnerable prisoners out of reach of 'strong' and violent prisoners, who should be kept under particular observation.

Identifying persons at risk of becoming a victim of violence, and persons who are potential perpetrators of violence, is a key element in the prevention of violence. As recommended by the WHO Regional Office for Europe, the initial medical assessment is a good way to identify vulnerable prisoners and prisoners who have experienced violence prior to their imprisonment and/or present with physical signs, and the health care professionals can help make recommendations for these prisoners or groups of prisoners, whilst respecting confidentiality.³⁸⁵

Cases seen by prison health staff which may involve violence, need to be investigated and classified appropriately. For instance, an accident which resulted in an injury should be investigated as to the sufficiency of safety procedures to prevent future cases and the same goes for a vio-

384 APT (2004). *Monitoring places of detention: a practical guide*. Association for the Prevention of Torture, Geneva, 2004. Available at: https://www.apr.ch/content/files_res/monitoring-guide-en.pdf

385 WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Denmark, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

lent episode. In some countries, every case of physical injury must be appraised by a forensic specialist.

Registration and documentation of violence (inter-prisoner violence, violence between staff members and prisoners as well as violence experienced by a prisoner before arrival) and other injuries is the duty of the prison health staff in collaboration with prison management. Data can help provide information on causes of violence, hence give hints on how to prevent violence and injuries in an institution. The problems causing violence may need structural intervention by authorities superior to the management of the institution and in that case the collected information may be useful in public or private discussions with decision makers about solutions, i.e. 'advocacy'.

Prison health staff should, as far as possible, document and follow up on violence. If possible at all, it is recommended that prison health staff have a reporting mechanism to an independent authority in place, to encourage that data on violence are treated in a neutral and confidential manner as a safeguard against reprisals. An independent authority could for instance be the Ministry of Health or a human rights institution.³⁸⁶ Reporting cases could be done anonymously or with the informed consent of the prisoner. In cases of serious violence, which are to be reported to the police as a crime (leading to another trial and possible sentence), informed consent is not required.

Monitoring methodology

When monitoring violence in places of detention, the monitoring team should aim to answer at least the following questions:

- Are cases of violence registered?
- To which extent do victims of violence consult the prison doctor?
- How does the prison doctor document signs of violence?
- In which cases is violence reported to the management?
- What is done to prevent violence from occurring?
- What is done to protect a prisoner who has experienced violence from future violence?

Monitors should look carefully into how the prison administration deals with prisoners with violent behavior. Use of force needs to be proportional and should not exceed what is deemed necessary to control the situation. Discipline should be maintained according to rules that are comprehensible to and known by all staff members and prisoners. Any case of violence should be investigated and analyzed as to its reason and consequences, which will include the possible role of staff members in the creation or escalation of a conflict. All cases where staff members use physical force should be registered and reported and should be evaluated by superiors as to its necessity and proportionality (see the chapter on the use of force in Section 4).

The monitor should ask the prison management about general violence prevention initiatives in the institution and about how a case of violence is followed up on. Questions could include how the institution tries to prevent violence and how gang members are being dealt with (for instance, whether or not they are being separated from other prisoners).

Interviews with prisoners should aim to get information about the daily life in the institution and on the prisoners' perspectives with regard to the occurrence, management and prevention of

³⁸⁶ WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Denmark, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

violence. Questions could include whether the prisoner feels safe in the institution and whether he/she has ever been a victim of violence (or in some way has been involved in a violent episode) in the current or a previous institution - which the prisoner may find easier and safer to talk about. The latter would not give information about the current institution as such, but would nevertheless be very useful to the monitoring team with the overall mandate to monitor places of detention in the country.

Interviews with prison health staff members could focus on the prison health staff's role in the assessment and documentation of cases of violence and on the medical and psychological support available to a victim of violence.

Prison guards can give valuable information about the daily life in the institution and will often be able to tell first-hand stories about episodes of violence that have happened in the institution. Questions that could be asked include for instance whether they have received any training in how to deal with conflicts/violence and how they follow up on a case of violence.

Observations during the monitoring visit could give the monitor valuable information about the relationships between prisoners and staff members. For instance, are these open-minded and mutually respectful, or authoritarian and maintaining distance? The monitor should also observe the relationships between prisoners. For instance, are these friendly and helpful, or fearful and hierarchic?

If a register on incidents of violence and accidents exists, the data from the register should be assessed. When looking into registers of violence, monitors should keep in mind that prisoners and staff can be reluctant to report on incidents of violence in general and maybe even more so in violent environments. Therefore, underreporting should always be considered, and the information should be triangulated with the information obtained from the individual interviews and possibly the medical records of prisoners who have alleged exposure to violence and were subsequently medically examined.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

WHO (2002). *World report on violence and health*. World Health Organization, Geneva, 2002. Available at: https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf;jsessionid=35F478A426DA61FADC2D7CA2D5E36BE1?sequence=1

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

WHO (1996). *Global Consultation on Violence and Health. Violence: a public health priority*. World Health Organization, Geneva, 1996. Available at: https://apps.who.int/iris/bitstream/handle/10665/179463/WHA49_R25_eng.pdf?sequence=1&isAllowed=y

WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional Office for Europe, Denmark, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

5.11. Death in custody

A death in custody refers to a person dying while residing in a place of detention. As defined in the Minnesota protocol on the Investigation of Potentially Unlawful Death, a death in custody is a 'death occurred when a person was detained by, or was in the custody of, the State, its organs, or agents. This includes, for example, all deaths of persons detained in prisons, in other places of detention (official and otherwise) and in other facilities where the State exercises heightened control over their life'.³⁸⁷ It also includes deaths in hospital facilities after immediate transfer from a state detention facility.

In many countries throughout the world custodial deaths are frequent, representing a serious public health concern with regard to the conditions of the institutions in which the deaths occur.³⁸⁸

The cause of death is the specific injury or disease that leads to death. The manner of death is the determination of how the injury or disease leads to death.

Manners of deaths in custody can be classified as follows:

1. Natural deaths
2. Accidental deaths - including for instance deaths due to fatal intoxications and deaths due to fire
3. Deaths due to suicide
4. Deaths due to homicide– including deaths due to inter-prisoner violence, prisoner-to-staff violence and staff-to-prisoner violence (including due to torture and excessive use of force, including physical restraint measures)
5. Undetermined

Ad 1. Natural deaths

Natural deaths refer to deaths caused by disease.³⁸⁹ Studies differ in their results on the prevalence of natural deaths in custody compared to in the general society. Several studies report higher mortality rates in prison populations, mainly due to a poorer overall health status in prisoners, higher prevalence of infectious diseases and higher prevalence of sudden unexpected deaths.³⁹⁰ Other studies however emphasize that mortality rates from natural causes of deaths are lower in prison settings than in the general population (for age-matched populations), which may be explained by the fact that admission to prison for some persons involves a chance to reduce their vulnerability to ill-health (for instance by reducing use of illicit drugs and having

387 UN OHCHR (2016). *The Minnesota Protocol on the Investigation of Potentially Unlawful Death* (2016). United Nations Office of the High Commissioner for Human Rights, 2016. Available at: <https://www.ohchr.org/Documents/Publications/MinnesotaProtocol.pdf>

388 Gaggioli and Bernice (2017). Death in Custody: Towards an International Framework for Investigation and Prevention. *Emerging Issues in Prison Health*. Pp. 35–53. Available at: http://link.springer.com/10.1007/978-94-017-7558-8_3

Larney et al (2014). Opioid Substitution Therapy as a Strategy to Reduce Deaths in Prison: Retrospective Cohort Study. *BMJ Open* 4(4): e004666. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987723/>

389 Olsson et al (2016). Risk Factors for Unnatural Death: Fatal Accidental Intoxication, Undetermined Intent and Suicide: Register Follow-up in a Criminal Justice Population with Substance Use Problems. *Drug and Alcohol Dependence* 162: 176–181. Available at: <https://www.sciencedirect.com/science/article/pii/S0376871616001514?via%3Dihub>

390 Fazel and Baillargeon (2011). The health of prisoners. *The Lancet* 2011; 377:956-65. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(10\)61053-7.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)61053-7.pdf)

better access to health care services).³⁹¹ What also needs to be kept in mind is that terminally ill prisoners are often transferred to a hospital or to their family before they die, and that therefore the death may not be registered as a natural death in custody.

The rapidly rising number of elderly prisoners, particularly in high-income countries, may cause an overall increase in numbers of death in custody.³⁹² Elderly prisoners suffer relatively more often from age-related conditions, and consequently account for an increasing proportion of deaths resulting from natural causes such as coronary heart diseases or cancers.³⁹³

Ad 2. Accidental deaths

Accidental deaths in custody may occur from any kind of accident, including for instance falling from a staircase or being caught in a fire. Fatal drug intoxications are also often classified as accidental, as it was not the intention of the person to overdose and consequently die from the intake of drugs.

Drug intoxications are a common cause of death both in custody and in the period following release. In fact, drug overdose is the leading cause of death following release from prison in several countries, especially during the first weeks.³⁹⁴ Moreover, fatal intoxications in places of detention may occur. This may occur due to illicit drug use in the prison by the prisoner who is likely to have a lower threshold to the drug, or as a consequence of careless storage and management of medication in places of detention, including a lack of proper care and thoroughness in the prescription of medication, causing medication errors and undesired side-effects of prescribed medication.

Fires that occur in places of detention too often have fatal consequences. For instance, in an overcrowded prison in Honduras more than 380 prisoners died in a prison fire in 2012. Most of them died due to the inability to escape their cells.³⁹⁵ Another example is a fire in a prison in Guatemala in 2017 where 41 adolescent girls died from burns and smoke poisoning. Officials and police officers were charged with manslaughter. The risk of death among prison populations in case of a fire has been studied within prisons in France, with the conclusion that the risk of death in case of a fire is nearly fifteen times higher in prisons than in the general population.³⁹⁶ The risk of death due to fire in places of detention could be reduced by implementing smoke detectors

391 WHO/Europe (2014). *Prisons and Health*. World Health Organization Regional office for Europe, Copenhagen, 2014. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

Fazel and Baillargeon (2011). The health of prisoners. *The Lancet* 2011; 377:956-65. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(10\)61053-7.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)61053-7.pdf)

392 Hayes (2017). *Aging Inside: Older Adults in Prison*. In: Emerging Issues in Prison Health. Bernice S. Elger, Catherine Ritter, and Heino Stöver, eds. Pp. 1–12. Dordrecht: Springer Netherlands. Available at: http://link.springer.com/10.1007/978-94-017-7558-8_1

393 Carter and Goodwin (2013). Understanding Clinical Review Following a Death in Custody. *Nursing Standard* 28(12): 54–59.

Maschi & Richter (2017). Human Rights and Dignity Behind Bars: A Reflection on Death and Dying in World Prisons. *Journal of Correctional Health Care* 23(1): 76–82. Available at: <https://journals.sagepub.com/doi/full/10.1177/1078345816685116>

394 Bukten et al (2017). High Risk of Overdose Death Following Release from Prison: Variations in Mortality during a 15-Year Observation Period: High Risk of Overdose Following Release. *Addiction* 112(8): 1432–1439. Abstract available at: <https://doi.org/10.1111/add.13803>

WHO/Europe (2014). *Prevention of Acute Drug-Related Mortality in Prison Populations During the Immediate Post-Release Period*. World Health Organization Regional Office for Europe, Copenhagen, 2014 (updated from original 2010). Available at: http://www.euro.who.int/__data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf

Binswanger et al (2007). Release from Prison — A High Risk of Death for Former Inmates. *New England Journal of Medicine* 356(2): 157–165. Available at: <https://www.nejm.org/doi/full/10.1056/nejmsa064115>

395 <https://www.nytimes.com/2012/02/16/world/americas/prison-fire-in-honduras-leaves-high-death-toll.html>

396 PRI (2018). *Global Prison Trends*. Penal Reform International, London, 2018. Available at: https://cdn.penalreform.org/wp-content/uploads/2018/04/PRI_Global-Prison-Trends-2018_EN_WEB.pdf

and by training prison staff. Furthermore, the presence of a fire escape- and evacuation plan is of key importance.

Ad. 3 Deaths due to suicide

For more on deaths due to suicide, see the respective chapter in this Section.

Ad 4. Deaths due to homicide

Violence constitutes an important cause of death in places of detention. In some contexts, violent deaths represent over 17% of deaths in custody.³⁹⁷ Violent deaths occur both as a result of prisoner-to-prisoner violence, staff-to-prisoner violence and prisoner-to-staff violence. Especially riots and fights between members of different gangs can cause violent deaths, which could often be prevented by careful classification. Also, homicides occur in prisons on a global scale. The occurrence of homicides in places of detention may be interpreted as an indicator of neglect, for instance insufficient - or lack of - assessments of cell-sharing risks and imported hostilities between prisoners, which would be measures to prevent homicides in places of detention.³⁹⁸

Deaths in custody may as well be a direct consequence of torture. There is, however, often a lack of knowledge about the causes of death among victims of torture, as autopsies are rarely conducted in cases involving torture. Therefore, the medical consequences of fatal torture often remain obscure.³⁹⁹

Disproportionate use of physical restraint measures and force may cause custodial deaths in cases where, for instance, physical restraint or excessive use of force causes the inability to breathe adequately or clear the airways. Moreover, the inability to move due to use of physical restraint may result in death caused by, for instance, thrombosis and lung embolisms, a risk that becomes relevant if the body position implies obstruction of veins for an extended period of time or if the person is unable to move for longer periods. Staff members need training in how to restrain violent persons, if strictly necessary, without putting the lives and health of these persons at risk. For more on the use of physical restraint measures, see the respective chapter in Section 4.

Ad 5. Undetermined deaths

The manner of death may remain undetermined despite a clearly established cause of death because the intention or cause of death is unclear. There is insufficient information about the circumstances surrounding the death to decide the manner of death. It may also be classified as undetermined when two or more conceivable causes of death are possible. An autopsy can help to determine the manner of death. An autopsy can be defined as a surgical procedure that consists of a thorough examination of a corpse by dissection to determine the cause, mode and manner of death or to evaluate any disease or injury that may be present for research or educational purposes.

397 UNHCHR (2019). *Human rights in the administration of justice. Report of the United Nations High Commissioner for Human Rights*. Available at: https://www.ohchr.org/Documents/Issues/RuleOfLaw/Violence/A_HRC_42_20_AUV_EN.pdf

398 Liebling (2017). The Meaning of Ending Life in Prison. *Journal of Correctional Health Care* 23(1): 20–31. Available at: <https://journals.sagepub.com/doi/full/10.1177/1078345816685070>

399 Pollanen (2018). The Pathology of Torture. *Forensic Science International* 284: 85–96. Available at: <https://www.sciencedirect.com/science/article/pii/S0379073817305388?via%3Dihub>

Relevance to preventive monitoring

Deaths in custody may be due to prison conditions which amount to ill-treatment and torture. Death may be a direct consequence of torture or a consequence of ill-treatment such as denial of prisoners' right to health and adequate care. If the cause of death is a consequence of inadequate conditions in a place of detention, it is a violation of international human rights and prisoners' right to life.⁴⁰⁰

With prison authorities' obligation to protect the lives of the prison population follows the duty to investigate any death that occurs in custody.⁴⁰¹ Yet, in many places of detention, there is a lack of awareness on the importance of such investigations, and custodial deaths are often classified as natural despite the lack of a proper investigation. Deaths which are classified as natural deaths may however involve prison conditions, which are controlled by prison authorities, such as lack of access to adequate health care, lack of continuity of care, lack of medication, side effects of prescribed medication, overcrowding, poor hygiene and sanitation, starvation and malnutrition.⁴⁰²

A qualitative study on death in custody argues that there is a need for international consensus on a definition of death in custody that acknowledges deaths related to the prison environment.⁴⁰³ Lack of sufficient prevention of avoidable deaths in custody, including those due to fire, riots or conflicts between gangs and individuals, is a failure of prison administrations to protect the health, safety and lives of the prison population. Prison administrations may moreover fail by disregarding international standards addressing the management of deaths in the institution, as well as international guidelines on investigating deaths in custody (see below). Failure to prevent and investigate death in custody may lead to continuation of dangerous conditions in prisons and to covering-up of torture. It may also indicate that authorities ignore inhuman and degrading conditions in their institutions, which should be remedied.

As an example, in 2017 The European Court of Human Rights declared that a violation of a prisoner's right to life had occurred in Russian detention. The prisoner died of TB in detention under the authorities' control. The Court found that the prison authorities had failed to protect the life of the prisoner, because the treatment of TB had been defective, primarily as no effective medication was provided for almost four months after TB had been diagnosed. Besides, the Court found that the prison authorities had failed to ensure that a thorough investigation was carried out into the circumstances of the death.⁴⁰⁴

International standards and guidance

The UN Mandela Rules include four specific rules addressing custodial deaths (Rule, 8, 69, 71 and 72). They state that information on the circumstances and causes of any injuries or death and, in the case of the latter, the destination of the remains, shall be entered in the prisoner file management system (Rule 8). In the event of a prisoner's death, the prison director shall at once

400 Gaggioli & Bernice (2017). Death in Custody: Towards an International Framework for Investigation and Prevention. *Emerging Issues in Prison Health*. Pp. 35–53. Available at: http://link.springer.com/10.1007/978-94-017-7558-8_3

401 UNOHCHR (2017). *The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016): The Revised United Nations Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions*. United Nations Human Rights Office of the High Commissioner, New York & Geneva, 2017. Available at: <https://www.ohchr.org/Documents/Publications/MinnesotaProtocol.pdf>

402 Bollmann et al. (2018). *Investigation of Deaths in Custody*. In: *Monitoring Detention, Custody, Torture and Ill-Treatment: A Practical Approach to Prevention and Documentation*. Pp. 231–247. Boca Raton: CRC Press, Taylor & Francis Group

403 Ruiz, et al (2014). Understanding Death in Custody: A Case for a Comprehensive Definition. *Journal of Bioethical Inquiry* 11(3): 387–398. Abstract available at: <https://link.springer.com/article/10.1007%2Fs11673-014-9545-0>

404 Case accessible at: <https://hudoc.echr.coe.int/eng#%7B%22documentcollectionid%22:%5B%22GRANDCHAMBER%22,%22CHAMBER%22%5D%7D>

inform the prisoner's next of kin or emergency contact (Rule 69). Rule 71 states with regard to investigation of custodial deaths, that *'...notwithstanding the initiation of an internal investigation, the prison director shall report, without delay, any custodial death, disappearance or serious injury to a judicial or other competent authority that is independent of the prison administration and mandated to conduct prompt, impartial and effective investigations into the circumstances and causes of such cases. The prison administration shall fully cooperate with that authority and ensure that all evidence is preserved'*. It also states that this shall equally apply when *'...there are reasonable grounds to believe that an act of torture or other cruel, inhuman or degrading treatment or punishment has been committed in prison, irrespective of whether a formal complaint has been received'*. Rule 72 states that *'the prison administration shall treat the body of a deceased prisoner with respect and dignity. The body of a deceased prisoner should be returned to his or her next of kin as soon as reasonably possible, at the latest upon completion of the investigation. The prison administration shall facilitate a culturally appropriate funeral if there is no other responsible party willing or able to do so and shall keep a full record of the matter'*.

Management and investigation of deaths in custody

Comprehensive guidelines regarding the investigation of deaths in custody, and the duties of those involved, are outlined in The Minnesota Protocol on the Investigation of Potentially Unlawful Death, originally written in 1991 and updated and published by The United Nations Office of the High Commissioner for Human Rights in 2017.⁴⁰⁵ The protocol *'aims to protect the right to life and advance justice, accountability and the right to a remedy, by promoting the effective investigation of potentially unlawful death or suspected enforced disappearance'*. It states that in line with international law, investigations should be prompt, effective and thorough, independent and impartial, and transparent.

Also the International Committee of the Red Cross published Guidelines for Investigating Deaths in Custody in 2013.⁴⁰⁶

Any death occurring in custody should be treated as suspicious until an investigation has been conducted by a qualified independent team, and all deaths should be investigated in compliance with international standards and guidelines.

Investigations of deaths in custody shall be conducted in order to clarify the circumstances of death, reduce trauma and provide an effective remedy for the family, determine responsible parties, and ensure the security of other prisoners. Clarification of circumstances, causes and manners of death may indicate patterns or practices linked to the death, which prison authorities must address in order to prevent future avoidable deaths.⁴⁰⁷

Investigations of deaths in custody include, but are not limited to, death scene investigations, examinations of the clothes of the deceased, examinations of the medical history of the deceased, and postmortem examinations. The results of all steps of the investigation should be thoroughly registered. In the case of expected deaths in custody, i.e. deaths due to diagnosed terminal illness, the investigation may be simplified.

405 UNOHCHR (2017). *The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016): The Revised United Nations Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions*. United Nations Human Rights Office of the High Commissioner, New York & Geneva, 2017. Available at: <https://www.ohchr.org/Documents/Publications/MinnesotaProtocol.pdf>

406 ICRC (2013). *Guidelines for Investigating Deaths in Custody*. International Committee of the Red Cross, Geneva. Available at: <https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4126.pdf>

407 ICRC (2013). *Guidelines for Investigating Deaths in Custody*. International Committee of the Red Cross, Geneva. Available at: <https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4126.pdf>

Prevention of deaths in custody

Prison authorities have a responsibility in protecting the health, safety and lives of prisoners residing in their institutions. Prison authorities should have in view whether deaths that occur in their institutions could have been prevented, for instance, whether inadequate health care is a contributing cause of deaths that are classified as natural, whether prison staff have received sufficient training in the fatal risks of physical restraint measures, whether smoke detectors and emergency plans in case of fire exist, whether homicides are properly prevented by sufficient risk assessments and appropriate interventions, and whether a programme for suicide prevention is in place. Furthermore, prison authorities should include in their view the prevention of deaths following release from prison, especially in terms of initiating exit programmes to prevent fatal drug overdose after release among opioid dependent prisoners (see for more the chapter on substance use disorders in this Section).

Registration of deaths in custody

Deaths occurring in custody should be registered by prison authorities, including the circumstances, causes and manners of death. The number of deaths in a place of detention may be underreported, as in-hospital deaths caused by disease, violence or injuries might not be registered as custodial deaths. Moreover, terminally ill prisoners who are allowed to be cared for by their families during the last period of their lives may also be excluded from the statistics. Furthermore, possible misclassification of manners of death may likely occur in the institution's registry, such as the classification of suicides as accidental intoxication and vice versa.⁴⁰⁸ As already touched upon, there may as well be a tendency of misclassifying non-natural deaths as natural, despite the lack of a proper investigation.

Monitoring methodology

A monitoring team should assess the practices in a place of detention regarding the prevention, management and investigation of deaths in custody. The monitoring team must be critical towards the institution's compliance with international standards and guidance, in terms of ensuring proper registration of the circumstances of deaths in custody and conducting sufficient investigations.

The monitor should ask the prison management about the general procedures in relation to deaths in their institution. Questions could for instance include what happens when a custodial death occurs and whether a death is reported to an independent authority. The management could also be asked about the prevention measures in place in the institution, aiming to reduce prisoners' risk of death due to violence, homicide, suicide, an accident, fire and use of physical restraint measures.

Interviews with prisoners could give the monitor some information about how a death of a fellow prisoner has been handled by the institution.

Prison health staff could, amongst other things, give insight in their role with regard to the management of deaths in the institution and the record-keeping.

Interviews with prison guards will give information on the procedures which are in place when a prisoner dies and on whether staff members have obtained any training in the topics relevant to

408 Olsson et al (2016). Risk Factors for Unnatural Death: Fatal Accidental Intoxication, Undetermined Intent and Suicide: Register Follow-up in a Criminal Justice Population with Substance Use Problems. *Drug and Alcohol Dependence* 162: 176–181. Available at: <https://www.sciencedirect.com/science/article/pii/S0376871616001514?via%3Dihub>

the prevention of deaths in custody, such as the prevention of suicide and self-harming and the safe use of physical restraint measures.

A monitoring team should assess all cases of deaths in a place of detention, including the different causes and manners of death. Such assessments require that the monitoring team requests data on deaths in the place of detention, that data is made available for the monitoring team, and that data have been systematically registered in the first place. Assessing the mortality and whether prisoners die from manners and causes that may be prevented, is crucial for a monitoring team. If detailed information exists (e.g. who died from what during the last year), the monitoring team could for instance assess medical records, death certificates, autopsy reports and other material from the investigation of the custodial deaths and ask themselves the following questions:

- Was the manner and cause of death well established?
- Has the institution sufficiently analyzed the case based on a thorough and independent investigation and sufficiently remedied identified shortcomings with a view to preventing future cases?
- Was the case a result of shortcomings in medical treatment?
- Which are the necessary amendments for the prevention of future cases (recommendations to the authorities)?

Thus, a monitoring team must scrutinize the institution's initiatives to prevent avoidable deaths in custody.

In the process of drawing conclusions and making recommendations for improvement, the monitor should always triangulate the information obtained from the different sources of information.

Further reading

ICRC (2013). *Guidelines for Investigating Deaths in Custody*. International Committee of the Red Cross, Geneva. Available at: <https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4126.pdf>

UN (2015). *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. United Nations, 2015. Available at: https://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6/ECN152015_L6_e_V1503048.pdf

UNOHCHR (2017). *The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016): The Revised United Nations Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions*. United Nations Human Rights Office of the High Commissioner, New York & Geneva, 2017. Available at: <https://www.ohchr.org/Documents/Publications/MinnesotaProtocol.pdf>

SECTION 6: MONITORING TORTURE

6.1. Introduction

The previous Sections have elaborated on a wide range of health issues, aspects of prison health services, as well as health factors, focusing on their relevance to preventive monitoring on torture and ill-treatment.

What has not been addressed so far are the consequences of different methods of torture for the physical and/or mental health of the victim. This knowledge will help the monitor to recognize specific health issues linked to certain methods of torture. It will also help the monitor in his/her conversation with a prisoner alleging torture and telling him/her about the case.

This Section will present some key methods of torture and consequences of torture, as well as a methodology on how to monitor torture (including identification and documentation).

6.2. Methods of torture

It is not possible to make an exhaustive list of torture methods being used around the world since new methods keep emerging. One important trend is the use of methods that may produce intense pain or suffering but leave no or only very limited marks on the body. Another important trend is the increasing use of psychological torture methods.

Certain features of torture are however independent of the methods used, and different methods can be applied with the same overall aims as e.g. producing fear, producing pain, and targeting the victim's needs of control, meaning and purpose.⁴⁰⁹

For some purposes, it may however be useful to distinguish between different types of torture. A frequent typology used is the distinction between physical, psychological and sexual torture. However, it is important to remember that this distinction is partly artificial, and that there is a significant overlap between the categories.

All types of physical torture may lead to severe mental suffering as well, and sexual torture contains elements of both physical and mental suffering. However, the distinction between different types of torture may still be useful to have in the back of one's mind when interviewing a victim of torture and when systematizing the information given by the victim.

Some examples of torture in the three categories are given below:

Physical torture:

Unsystematic beatings (including kicks and punches), systematic beatings (e.g. *falanga*), positional torture (constraint of movement, forced positioning), suspension, burnings, electric shocks, asphyxiation, chemical exposure (acid, chili pepper etc.), cuts and stabs, forced ingestion or injection, and exposure to extreme heat or cold.

Psychological torture:

Deprivation of sleep, deprivation of normal sensory stimulation, humiliation, mock executions, threats to the victim himself or to others e.g. family members, forcing victim to witness torture being inflicted on others, and violation of taboos (e.g. forcing a Muslim to eat pork).

Sexual torture:

Violence against genitals, rape, forced masturbation, forced nudity, introduction of objects into genitals.

Often, different types of torture are used together so as to increase the victim's suffering. And often, well-defined patterns of torture are seen in particular contexts. It adds to the credibility of an account of torture if the pattern described is consistent with already existing knowledge about torture in that specific location. Therefore, the monitor should before each monitoring visit familiarize him/herself with any previous accounts of torture in the institution/area. Knowledge about the torture methods typically used in a particular context will help the monitor assess the credibility of the information given by an alleged victim of torture. Torture should however never be excluded if a person gives an otherwise credible description of having been subjected to other types of torture that do not fit with the typical local or regional pattern.

Very often, torture survivors report having been subjected to more than one torture method. Often, when different methods are used in combination, one torture method may potentiate the

409 Pérez-Sales, Pau. *Psychological torture: definition, evaluation and measurement*. New York, Routledge, 2017.

effect of other methods. For example, sleep deprivation may lower a person's pain threshold thereby increasing the effect of physical torture methods. Sleep deprivation may also add to the confusion of the victim and thereby make him/her more susceptible to threats. In some contexts, the combination of different torture methods has been systematized to the extent where names exist covering a combination of different methods like, for example "the five interrogation techniques" used by the British military in Northern Ireland, which consisted of prolonged wall-standing, hooding, subjection to noise, deprivation of sleep, and deprivation of food and drinks.⁴¹⁰

In conclusion, torture methods are many, and the monitor needs to understand how to systematize what he/she hears about different torture methods, both the ones that he/she has already heard of before and new ones coming up during an interview. Knowing about the different types of torture will not only enable the monitor to ask the right questions and get the full picture of what happened, but it will also make him/her able to note down what he/she has heard in a coherent and understandable way.

The monitor should always ask for the victim's informed consent to document the case and to do any kind of follow-up.

410 See: https://en.wikipedia.org/wiki/Five_techniques

6.3. Consequences of torture

Just like torture methods, the consequences of torture at the individual level may be categorized in different ways. Doctors will use the terms acute and long-term, where acute consequences refer to the consequences that one may experience in direct relation with the trauma, i.e. when the trauma happens, and in the days or weeks immediately following the trauma. Long-term consequences will be consequences that are still there or occur after weeks, months, or even years. If the person still experiences symptoms after a while, and these do not subside with surgery or other one-off interventions, one may talk about the symptoms as being chronic, i.e. of a long-term nature.

Another way of systematizing the consequences of torture is according to the parts of the person that are affected. Physical consequences have to do with the bodily symptoms, whereas psychological consequences have to do with the symptoms of the mind, and social consequences have to do with the consequences that the individual experiences in his/her social life in interaction with others. This may for instance include the victim's relation to family members and others, but also his/her connection to the labor market, house, social status, social activities etc. Often, the consequences will not be limited to one aspect of life, and a notion frequently used is that consequences of torture are *bio-psycho-social* in nature. Obviously, in a prison setting the social consequences of torture may be of a different nature to what is seen in the outside community and could for instance include a victim of torture not feeling confident among others and isolating himself from the co-detainees and the staff.

Symptoms may fluctuate over time and depend on a lot of different factors like for instance the duration of the torture, the time that has passed since the torture occurred, the victim's vulnerability and overall situation, his/her resilience, his/her access to treatment and rehabilitation etc. For some, symptoms may be re-activated when they go through difficult times or when they are confronted with situations that remind them of what the torture they experienced (re-traumatization).

Physical consequences of torture

In the acute phase, torture gives rise to different physical symptoms and injuries. Typical injuries that are immediately visible include, but are not limited to, bruises, excoriations, swellings, burns, open wounds, and fractures – or in other words, the same types of injuries that one may see after other types of trauma not related to torture. One of the challenges faced when identifying a victim of torture is therefore to assess whether an injury is the result of torture or another trauma. For this, the victim's story is paramount, even if the interview is done after the acute injuries have healed. It is important to ask the survivor him/herself to explain what acute symptoms and injuries he/she suffered immediately after the torture. This might increase the credibility of the survivor. Also, some acute lesions have a typical appearance like for example the so-called “tramline bruises” (two parallel linear bruises separated by a paler, undamaged section of skin) following beating with a rod-shaped hard object, and the burns following electrocution or cigarettes to the skin.

The acute injuries following torture will typically be accompanied by pain, but in case nerve damage has ensued, for example after suspension or severe burns, numbness may also occur.

Most acute, visible lesions (bruises, excoriations etc.) heal within a maximum of about six weeks, some of them without leaving any permanent marks, which explains why a victim of torture must be examined by a qualified medical doctor as soon as possible after the trauma, so that any acute lesions can be properly documented before they disappear. This is why the

monitor needs to look carefully into the initial medical assessment of detainees upon entry into an institution, as most torture will have happened in a previous detention facility, most often a police station.

In some cases, the sequelae of the torture will be visible even after months or years, e.g. burn scars, loss of hair, changed skin pigmentation, and incorrect healing of fractures. Often, however, this will not be the case and the visible signs of torture may completely disappear. It is therefore important to remember that a lack of physical signs does not imply that torture did not take place.⁴¹¹

Unfortunately, once the skin has healed after an acute lesion like a wound, and left a scar, it is very difficult to assess the age of the scar and possible cause. This is another reason why it is important that lesions are documented as soon as possible after they occurred.

Torture may affect practically all organs of the body. Some torture consequences can be related directly to a particular form of torture or a particular organ being involved, but others are more diffuse. Some examples of consequences directly linked to particular methods of torture are:⁴¹²

Skin – wounds and scars following burns or electrocution, swellings and bruises following beatings, excoriations following strangulation with ropes or beatings with objects with a rough/irregular surface, lacerations (irregular tear-like wounds) following blunt trauma

Ears – hearing problems following teléfono torture leading to rupture of the tympanic membrane or damage to the inner ear

Eyes – problems with eyesight following beatings leading to hemorrhages in the eye or dislocation of the lens

Face including nose and jaw – fractures of facial bones following beatings

Teeth – loss of teeth following blows to the mouth or dental torture

Heart – acute cardiac arrhythmia following electrocution

Lungs - acute and chronic breathing problems following strangulation, asphyxiation and inhalation of foreign body substances (e.g. after waterboarding or dry asphyxiation)

Trunk – broken ribs following beatings

Internal organs – inner bleedings after beatings

Musculo-skeletal system – impaired movement of joints following suspension, fractures of bones, loss of soft tissues in the foot soles following falanga

Genito-urinary system – sexual dysfunction, after sexual torture, and sexually transmitted diseases and pregnancies following rape

Nervous system – damage to facial nerves leading to facial paralysis and sensory disturbances following blows to the head, brain damage following blows, beatings to the head or asphyxia in

411 UN (2004). *Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Para 176-186*. United Nations Office of the High Commissioner for Human Rights, 2004. Para 157-159, 161. Available at: <https://www.ohchr.org/Documents/Publications/training8rev1en.pdf>

412 UN (2004). *Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Para 176-186*. United Nations Office of the High Commissioner for Human Rights, 2004. Available at: <https://www.ohchr.org/Documents/Publications/training8rev1en.pdf>

relation to e.g. strangulation or water boarding, paralysis and sensory disturbances due to nerve damage after blows or, fractures, overstretching during suspension or forced positions etc.

Some of the physical complaints presented by victims of torture are, however, not necessarily linked directly to an identifiable direct trauma to one particular body part. The reasons for this are many: the victims may not be able to remember in all detail what happened to them, backpain may result from the body trying to compensate for pain in legs and feet resulting in different walking patterns, nerves may have been damaged in one body part leading to pain in the body part served by that nerve etc. What is seen is that torture survivors often present to a doctor months or years after the torture took place with chronic problems like headaches, back and muscle pains, gastrointestinal symptoms, and sexual dysfunction. These unspecific symptoms may be of fluctuating nature, i.e. of different intensity at different times, and they may be influenced by many other factors, e.g. treatments received, the survivor's psychological well-being etc.

Psychological consequences of torture

A victim of torture goes through a very extreme situation during which he/she is under the absolute control of the torturers and is rendered completely helpless. The methods of torture that do not inflict direct physical pain all have the aim of adding to the psychological pain and "breaking the mind" of the victim or humiliating him/her to make him/her confess, give information etc. This may be done by making the victim confused or disoriented, fearful, desperate, and lonely and completely deprived of his/her own free will, autonomy and dignity.⁴¹³

Therefore, victims of torture are often left with severe psychological symptoms, either alone or on top of the physical symptoms. Common psychological symptoms include depression, anxiety, insomnia, nightmares, flashbacks, anger outbursts and memory difficulties. These psychological symptoms may be severe.

Physical consequences can – as stated above – be directly linked with a specific torture method, e.g. beatings on one particular body part leading to pain and physical changes in that same body part. In some instances, a particular psychological symptom may also be directly linked with what happened to the victim, e.g. extreme anxiety when the victim is exposed to people wearing uniforms resembling the uniforms worn by the perpetrators. Often, however, the psychological consequences are of a more non-specific nature and – like pain moving from one body part to another - cannot be directly linked with specific torture methods. One particular possible sequelae of torture is post-traumatic stress disorder (PTSD), which is focused on specifically in Section 5, chapter on mental health problems.

Social consequences of torture

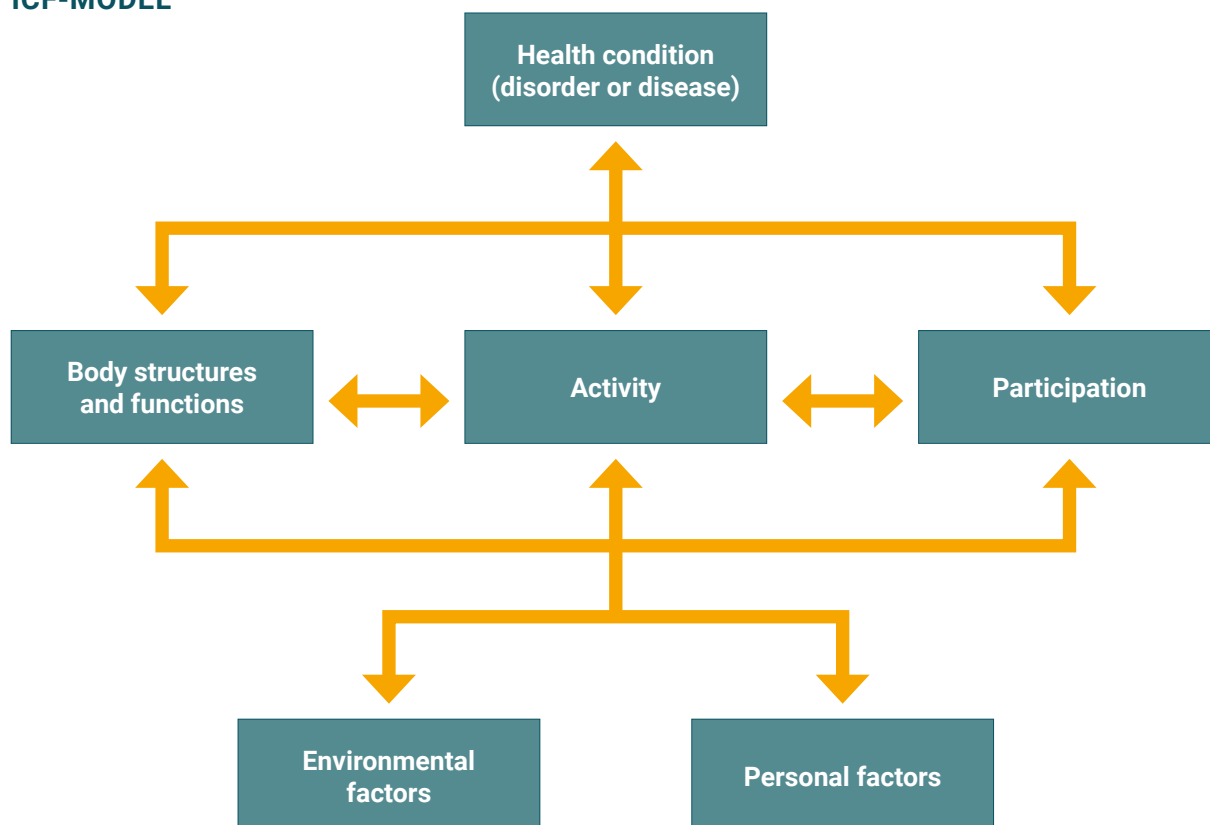
Torture may in many instances give rise to social consequences for the victim and his/her family. Many, if not all, persons who have spent time in detention face challenges when returning to freedom, including social isolation, loss of job and income, problems with family life etc. The physical and psychological consequences of the trauma that victims of torture are suffering are adding to these challenges.

Many different factors add up to influence the types of social consequences that a victim of torture may be facing. One model that may help analyze the interplay between different factors

⁴¹³ See for example the Torturing Environment Scale in Pau Pérez-Sales: Psychological torture: definition, evaluation and measurement. New York, Routledge 2017.

is the ICF-model presented in WHO's framework International Classification of Functioning, Disability and Health.⁴¹⁴ The ICF model is shown in figure 7.

FIGURE 7.
ICF-MODEL



Reference:

WHO (2001). International Classification of Functionality, Disability and Health, p.18. World Health Organization, Geneva, 2001. Available at: <https://apps.who.int/iris/bitstream/handle/10665/42407/9241545429.pdf;jsessionid=313069D-2F593CC2199109F44592A770E?sequence=1>

The ICF-model explains that different factors may influence a person's level of functioning and thereby how he/she is able to engage and participate in social and family life etc. In other words, a person's level of functioning is not only dependent on for example the bodily problems that he experiences but also on the types of activities that he/she is supposed to perform (e.g. whether his/her job is physically or psychologically demanding). Adding to this are environmental and personal factors, also called contextual factors. For example, someone with an understanding workplace and a supportive family may be better able to deal with an anxiety disorder than someone who does not have this and is staying in a place of detention. And someone who by nature has a resilient personality may be better able to cope with the adjustments necessary if the torture has given rise to a physical handicap. The opposite is also true: If someone has a physical or mental problem following torture and on top of that experiences extreme pressure because of his/her imprisonment, he/she may experience the consequences of torture more strongly.

In societies, where people run the risk of being tortured when being accused of crimes or serving sentences for crimes committed, when being politically active or belonging to minority groups, fear and a lack of trust in authorities emerges. This may have huge implications on

414 See WHO website: <http://www.who.int/classifications/icf/en/>

how people react in different situations and in the society at large. Perpetrators of torture may themselves experience psychological problems after having tortured others. Professionals like doctors dealing with victims of torture may become secondarily traumatized. And spouses, children, other family members and friends may see their lives and relations changed when one of their loved ones experienced torture or suffers from the consequences of it.

6.4. Monitoring methodology

When monitoring torture in an institution, the health monitor could make use of all information sources. The monitor should first identify the possible torture, either by an allegation, a suspicion, or an observation, and thereafter document what he/she has heard and/or seen.

Identification

Monitoring torture in an institution is not an easy task, as victims may be unwilling or too scared to talk about their experience and staff members will usually do everything to prevent the monitor from coming across a victim or tools that may be used for torture purposes.

Before conducting the monitoring visit, the health monitor needs to become familiar with the local context and the most common forms of torture and ill-treatment. This means that in addition to a theoretical understanding of the legal definition of torture and its consequences, the monitor should gain as much knowledge as possible about the general treatment of detainees in police stations and other places of detention, and also about the most prevalent torture methods in order for him/her to look for the right things during the monitoring visit. The monitor should also investigate whether torture or ill-treatment has previously been reported from the specific institution visited. This knowledge will make it easier for the health monitor to be properly prepared and ask the right questions to the prisoners in order to collect the required information.

During the monitoring visit, the monitor should at all times be attentive and alert in order to identify (possible) cases of torture and tools. The monitor may encounter a person who alleges to have been tortured, or a person whom the monitor suspects to have experienced torture. In such cases, the methodology for monitoring torture usually consists of the following three components:

- a. A monitor's initial interview with a person in which allegations of torture are brought up or suspicions arise.
- b. A possible supplementing interview by the health monitor (see below).
- c. Collection of other evidence, such as photographs of tools that allegedly have been used or may be used for torture in the institution, medical records, and photographs of injuries.

If the initial interview is done by a member of the monitoring team not being the health monitor, a supplementing interview by the health monitor should be aimed for in order to assess whether there are any visible marks or mental health conditions that may indicate that torture took place, and in order to assess the allegations in light of what is told about acute sequelae and current symptoms.

Interviews with prisoners would be a key source of information to the monitor, while he/she could also talk to prison management, prison health staff and prison staff about the issue. Prison management could for instance be asked whether there ever has been fired a staff member because of being alleged/suspected of having ill-treated a prisoner. Management could also inform the monitor whether there have ever been torture cases reported by the institution. Prison health staff could for instance inform the monitor whether they have ever come across a prisoner who had been ill-treated and if yes, how suspicion arose and how this was followed up on. Prison staff could be asked if they had ever experienced/witnessed torture in this facility.

Merely observing while conducting a monitoring visit, may make the monitor see tools or instruments that may be used for torture purposes. Medical records could be inspected for any reference to a person being ill-treated.

Documentation

The health monitor, like any health professional, has the ethical obligation to document and report torture. In case a monitor encounters a prisoner, who alleges to have been tortured, the monitor should always aim to follow-up on this case, and ask the prisoner for his/her informed consent to do so.

The gold standard for investigating and documenting torture and ill-treatment is described in the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment (Istanbul Protocol).⁴¹⁵ However, the health monitor usually does neither have the time nor the circumstances to investigate and document as detailed as presented in detail the Istanbul Protocol. He/she should however be familiar with the descriptions of physical evidences and of psychological consequences of torture, as outlined in chapter V and VI of the Istanbul Protocol, and with the Istanbul Protocol Principles as outlined in annex 1 of the Istanbul Protocol.

Good interviewing skills are fundamental for successful information gathering and documentation. As noted in the Istanbul Protocol in paragraph 100, one should *“allow the person to tell his or her own story, but assist by asking questions that increase in specificity”*.

The health monitor should aim to get the following information:

- **Who:** Who were the perpetrators? If unknown, can they be described in any way (clothes, age, sex, looks, language)? The description of any witnesses to the torture is important for a future criminal procedure. Note that witnesses could also include cellmates present when the victim came back from interrogation.
- **What:** What kinds of physical, psychological and sexual torture was the victim exposed to? Which torture tools were used (cables, plastic bag, generators, strings etc.)? Which body parts were involved? What was the duration of each method? This information should also include a description of the immediate bodily or psychological symptoms/sequelae of the torture, as noticed by the victim.
- **To Whom:** Who was exposed to the torture? This includes a description of the identity of the victim including features of the individual of significance to the impact of the methods used (e.g. physical or mental conditions, age, sex, ethnicity or other characteristics).
- **When:** When did the torture take place? This includes the date and duration of the arrests and detentions and description of when the different methods of torture were applied to the victim.
- **Where:** Where did the torture take place? This includes the place(s) of detention, if known, where the victim was detained, including a description of the premises as good as possible. In particular, unique features of the rooms and cells, which could be used for a later identification of the place, are important to ask for. The monitor could inspect these facilities while there, as evidence of torture could be found.

415 UN (2004). *The Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment*. Office of the UN High Commissioner for Human Rights, 2004. Available at: <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

- **Why:** Why was the person tortured? The motive for the torture is important for understanding the background and for identifying the perpetrators. Classical motives are to obtain information or a confession, or to punish the victim.

Several factors may complicate the task of getting information on all the above aspects. These include for instance that the victim may be traumatized and accordingly have difficulties remembering and/or giving a coherent account of what he/she experienced and the circumstances surrounding it, or that he/she may fear reprisals if he/she is still in the institution where the torture took place and is therefore afraid to share information with the monitor. It may also be that the actual history may be quite complicated, for instance including many arrests and detentions, many interrogations during each detention and many torture episodes and methods. Another complication may be that the victim may be re-experiencing the torture by telling the story, and that therefore the documentation must be stopped.

If time is limited, the health monitor may not be able to collect information about all of the above points. If the health monitor needs to prioritize and is able to guide the interviewee to talk about certain issues, the most important from a health perspective would be the **What** and **When** since the answer to these questions will help the health monitor interpret the coherency of the story in relation to the potential physical findings. However, this does not mean that the other types of information are not relevant to the health monitor since he/she is part of a general monitoring team for whom all information is important, only that some of the information may be collected by other members on the monitoring team who are not health professionals.

The health monitor should note down what he/she hears from the victim and if possible and appropriate, perform a basic medical examination of the victim. This should be undertaken in a way that takes into account the vulnerability of the victim and minimizes the risk of re-traumatization. With the consent of the person, the health monitor should also make photographic documentation of physical signs of torture whenever possible. If possible, a forensic ruler should be used for the photos to illustrate size and colour of lesions, and photos should be clearly marked with date and a code identifying the victim. A monitor may meet victims experiencing both acute and long-term/chronic consequences of torture and should be aware of how symptoms may develop over time to properly assess what he/she hears and sees. The possibility to collect additional evidence inevitably depends upon a number of factors, including time allocated, the presence of any witnesses, conditions for conducting the interview and the possibilities for the monitors to inspect medical records etc.

As mentioned in Section 2 of this manual, conducting a medical examination of a prisoner could only be relevant in case a prisoner alleges to have experienced torture. In the event that a prisoner claims to have e.g. a skin condition or another visible health condition which he/she claims has not been dealt with adequately by the prison health service, the health monitor may want to have a look at this, but it is not the task of a health monitor to perform an actual medical examination. Such cases should primarily be used to analyze the way in which protection systems against torture and ill-treatment as well as the health system in the institution work, i.e. searching for the causes of such incidents and verifying whether they are casualties or part of a pattern. If the health monitor briefly examines a prisoner with a health condition that is not related to torture, the monitor should make it perfectly clear to the prisoner that in doing so he/she will not assume the responsibility of the treatment which still lies with the health professional in the institution.

Follow-up

As a general rule, the monitor would need the informed consent from the torture victim to use the information obtained during the interview/examination in a person-attributable way and for follow-up. This could for instance be to request a full examination of the victim by a forensic doctor in line with the Istanbul Protocol. The monitoring team needs to be well aware of the procedures in the country in which they work, e.g. how and when to involve the public prosecutor, the police and prison authorities at central level. In exceptional cases, the monitor should use the information also when informed consent is not given. This could for instance be justified if many others are at risk of experiencing the same torture/ill-treatment if nothing is done. Information could also be used more generally and not personal-attributable in the monitoring report about the place of detention, without actually forming part of a medico-legal report. Also, observations of tools and instruments that may be used for torture purposes should be described in the monitoring report of the visit.

Further reading

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ANNEX 1: LIST OF KEY INTERNATIONAL STANDARDS AND GUIDANCE REFERRED TO IN THIS MANUAL

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DIGNITY MANUAL

MONITORING HEALTH IN PLACES OF DETENTION

AN OVERVIEW FOR HEALTH PROFESSIONALS

By Brenda van den Bergh, Lisa Michaelsen, Marie Brasholt and Jens Modvig

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