
# Explanatory Memorandum to Recommendation on the Ethical and Organisational Aspects of Health Care in Prison

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# Explanatory Memorandum to Recommendation (98) 7 on the Ethical and Organisational Aspects of Health Care in Prison

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**on the Ethical and Organisational Aspects of Health care in Prison**

## GENERAL CONSIDERATIONS (COMMENTARY ON THE PREAMBLE)

Generally, medical ethics can be defined as "special ethics appropriate to the conditions of practice of a profession, in this case, medicine [...] Professional ethics must guarantee the good practice of a profession taking account of its involvement in a society which is itself generally regulated by morals, laws and the law".[1]

Medical ethics have gradually been codified since the Second World War, inter alia, under the auspices of the World Medical Association (WMA).[2] There are, however, great variations among European countries and, at present, the sanctions resulting from an infringement of the rules of medical ethics are very diverse. Furthermore, it must be remembered that, despite the differences to be observed among national codes of ethics now in force, the origins of the spirit of medical ethics are to be found in very ancient texts such as the "Hippocratic Oath", which remained the essential ethical reference until the twentieth century.

It is essential to emphasise that, despite the specific nature of health care in prisons, the major principles of professional and medical ethics laid down in international texts must also be taken into consideration in medical practice in prisons.[3]

At European level, the following should be mentioned as reference texts to be taken into consideration as basic sources in this area: the Convention for the Protection of Human Rights and Fundamental Freedoms of 1950; the European Social Charter of 1961; the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment of 1987, the Convention on Human Rights and Biomedicine of 1997, the Recommendations of the Committee of Ministers (90) 3 concerning medical research on human beings; (93) 6 on prison and criminological aspects of the control of transmissible diseases, including Aids and related health problems in prisons; (87) 3 on the European Prison Rules as well as Recommendations 1235 (1994) on psychiatry and human rights, and 1257 (1995) on the conditions of detention in Council of Europe member states, prepared by the Parliamentary Assembly.

In view of the conditions specific to prisons which involve taking security criteria into account, it must be said that practising medicine in prisons is a "high risk activity" since medical criteria and security criteria can sometimes contradict each other.

In this context, laying down firm rules on medical ethics and identifying the ethical issues essential for ensuring that prisoners are provided with proper health care entails drawing up and promoting principles and recommendations that are likely to guarantee adequate medical practice in the special context of prison.

Already mentioned in the third general report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the following principles have gradually been identified to define the essential criteria on which the care of prisoners should be based: access to a doctor, equivalence of care, patient's consent and confidentiality, professional independence.[4]

Compliance with these principles now seems fundamental for providing adequate health care in prisons, which is why they are the subject of this recommendation. Furthermore, a number of precise situations specific to prisons are addressed in the recommendation in order to identify the ethical issues that must determine the choices and priorities of health care staff working in prisons.

## COMMENTARY ON THE RECOMMENDATIONS IN THE APPENDIX

### I. Main characteristics of the right to health care in prison

A. Access to a doctor

1. When entering prison, all prisoners should be able to have access to a member of the prison health service without delay. The interview and medical examination on admission, which might also include an evaluation of the prisoner's mental health, should be carried out by a doctor (cf. paragraph 29 of Recommendation (87) 3 on the European Prison Rules); however, availability of staff must be taken into account and the new prisoner's first contact with the medical service may on occasion be carried out by a fully qualified nurse responsible to a doctor to whom he or she may transmit any request for a consultation or care necessitating the involvement of a qualified doctor. While in custody, all prisoners should be able at any time to have access to a doctor or a fully qualified nurse without undue delay.

2. Health care staff, which includes qualified doctors, nurses and all other health professionals, may well be available on a part-time basis in establishments which care for a limited number of prisoners, particularly if the majority are young and healthy. On the other hand, the large institutions require full time health care staff, reinforced by additional part- time staff when necessary, especially to assist with out-of-hours cover. Health care staff working in prison should be given the opportunity to periodically return to the health care system in the community.

3. Prison health care services should be able to provide outpatient consultations and emergency treatment. Accordingly, every prison should have a trained person able to provide first aid on the premises at all times, and a doctor should be on call at all times outside normal consulting hours. Access to emergency medical care should not be subject to any delay resulting from non-medical criteria. The use of medical resources in the community should be extended to prisoners in support of the overall treatment approach of closer integration with the community. This might involve recourse to outside consultants to assist the prison doctor or transfer of the prisoner to appropriate outside medical services.

4. Access to a doctor should be ensured at any time during a twenty-four-hour period. Depending on the size of the institution concerned this may well require the participation of part-time staff. The availability of first aid treatment must always be guaranteed at all times, and in the event of a serious emergency the management must be alerted. The active participation and commitment of the custodial staff is essential. Part of the training of prison officers should be devoted to basic first aid.

5. In view of the high incidence of psychiatric problems occurring among prisoners, the availability of a multidisciplinary psychiatric team, not only in the large establishments, but also in the smaller isolated prisons, is a very important priority. Such a team should comprise both psychiatrists and also psychologists, psychotherapists, occupational therapists and counsellors. It may be that psychiatrists working full-time in large institutions could visit smaller satellites on a regular basis.

6. The services of a qualified dentist should be guaranteed at least for dental emergencies as well as for treatment that may be programmed according to length of prison sentence and prisoners' detention regimes. Generally, the service provided by a qualified dentist in prison should be sufficient to meet the needs of the prison population, especially prisoners who are drug addicts, whose dental health is often very poor.

7. Close co-operation between prison administration and local public and private drugs dependency clinics is fundamental, particularly when the prisoner is released into the community, and his after-care is arranged. It is extremely helpful to nominate a liaison officer to arrange for such co-operation in every case of drug dependency.

8. In the event that a serving female prisoner is found to be pregnant, there is a responsibility on the part of the prison authority to ensure that, in her vulnerable state, the expectant mother is well cared for either within the prison system or by outside agencies. If the policy is to release all pregnant women and rearrest them after delivery in order to serve their full sentence, or, if the policy is to detain them in prison in order to continue their custodial sentence, antepartum, intrapartum, and postpartum care should always be the responsibility of an outside hospital. At no time should the baby be delivered within the prison.

9. Transfer of prisoners to a hospital should be appropriate to their state of health, both as regards means of transport and speed of transfer. When hospital treatment is carried out in a secure unit in a civil hospital, it is important that there be close co-operation between the hospital unit and the health services of the prison referring prisoners. This guarantee would be fulfilled especially where the medical and nursing staff working in the hospital unit are also on the prison health care staff.

B. Equivalence of care

10. A prison health care service should be able to provide general medical and dental treatment, as well as preventive medicine (for example early detection of cancer), in conditions comparable to those enjoyed by the general public. The aid of specialists (doctors, physiotherapists, etc.) should be guaranteed according to the same principle of equivalence of care. Except in cases expressly provided for by law, the decision to seek a second medical opinion should be taken by the doctor responsible for the health of prisoners. When a second opinion is required, the prison health service should call upon a competent external doctor.

11. In order to guarantee the principle of equivalence of care, the competent authorities should ensure that appropriate and sufficient medical, nursing and technical staff, as well as premises, installations and equipment are available to prison health care services; furthermore, the organisation of prison health care services should be functional and modelled on that of health services available to the general public, while taking account of the specific aspects of prisons. To this end, a medical file should be established for every patient and contain all the information likely to guarantee appropriate medical care (anamnestic information, diagnoses, treatment, specialist examinations and consultations, etc.). A well-organised prison health care service is an essential guarantee that the treatment given in prison accords with the principle of equivalence to the community outside.

12. In most European countries the provision of health care in prisons is under the responsibility of the Ministry of Justice (or, in some cases, of the Ministry of the Interior) and the medical services are organised by the prison administration. The Ministry of Health is responsible for providing health care in only a few countries. The recommendation abstains from suggesting one single model of health care provision and of related institutional arrangements. It emphasises however that the Ministry of Health should have an enhanced responsibility in such matters as the evaluation of hygiene, the assessment of the appropriateness of health care and the organisation of health services in prison. In order to ensure optimum health care for prisoners and to implement the principle of the equivalence of health care in prison and the community, the various ministries and services concerned should endeavour to devise an integrated health policy for the prison system. This would involve close co-operation and a clear definition of responsibility.

C. Patient's consent and confidentiality

13. This section deals with an essential aspect of medical ethics, as both consent to medical treatment and confidentiality are concepts and values now almost unanimously accepted in professional and general ethics and in law. Freedom of consent to medical treatment and confidentiality are not only fundamental rights of the individual, but also the “cement” of the necessary relationship of trust between doctor and patient, especially in prisons, where prisoners are not usually able to choose their doctor freely. Not only should the doctor and nursing staff carry out consultations on a confidential basis, but they should also see that sick prisoners' medical records are kept in a place where protection of the confidentiality of medical documents can be guaranteed. For example, medical records may be kept in a place to which only the medical and nursing staff have access, or they may be placed in a locked cupboard used only by the health care staff.

14. The existence of “free and informed” consent to medical treatment presupposes the ability to understand, which should always be carefully examined in relation to the particular situation (“in concreto”), notably as regards persons suffering from a psychiatric disorder or an illness liable to diminish their ability to understand and make decisions. If necessary, the prison doctor may seek the opinion of a psychiatrist where he or she has a reasonable doubt as to the patient's ability to understand . Where the patient is able to understand, his or her consent to medical treatment must be:

– free: freedom of consent principally means a decision taken in the absence of any external constraint or pressure; the prison doctor should take care to ensure that the patient's consent is not obtained as a result of any advantage, personal or medical, not directly related to the situation under consideration;

– informed: patients can only express their will in so far as they have all the information enabling them to take a decision. The patient must therefore be provided with detailed information concerning the diagnosis and prognosis of the illness, the treatment, including the risks resulting from the proposed treatment and the possible therapeutic alternatives, including the risks relating to lack of treatment.

15. This paragraph deals with two other important aspects of the patient's consent to medical treatment. First, consent to medical treatment should also be sought from a patient suffering from a psychiatric illness, in so far as his or her ability to understand is not impaired. Furthermore, obtaining the patient's consent, especially in the case of psychiatric pathology, is essential if a “therapeutic alliance” is to be formed likely to make the patient more committed to the medical treatment offered. The situation in which a patient, who is able to understand, refuses medical treatment after receiving full, detailed information must also be taken into account. This is informed “non-consent” that every patient has a full right to manifest. However, such an attitude may sometimes result from a conflict relating to non-medical issues; this is particularly the case when a prisoner goes on hunger strike to protest against a judicial or administrative decision. In this type of situation the doctor has to check the state of health of a person without being able to intervene in the process that is the source of the deterioration in their health. It is then appropriate to record in great detail in the patient's medical file that he or she is able to understand and has refused treatment after being given detailed information.

16. As an extension of the previous remarks it follows that any derogation from the principle of free, informed consent by a person who is able to understand must be based upon law and concern only exceptional circumstances which are applicable to the population as a whole. This is, in particular, the case of certain infectious diseases such as tuberculosis, of which there is a high incidence in prisons for various reasons (poor health of prisoners, overcrowding, etc.) and certain sexually transmitted diseases (syphilis, etc.). Emergency situations where the doctor has a duty to take every appropriate measure to restore the patient to health when the latter is unable to understand (for example, because of trauma with secondary coma) must also be excepted; the patient's consent is presumed in this situation.

17. This paragraph states the conditions in which the prisoner's right to obtain a second medical opinion may be exercised. It is interesting to note that this right often conflicts with financial criteria, as it is reasonable for prisoners or their

families to bear the cost of calling in a doctor from outside the prison's health care service. In fact, although this right may be conferred on all prisoners, application of it comes up against inequality in their respective financial situations.

18. When a prisoner is transferred to another prison, his or her medical records, or a detailed medical report, should be transmitted to the doctor who will be treating the prisoner in future. It is important that the prisoner be informed about the transmission of medical records or reports and he or she should be given the possibility to object. When the prisoner is released, with the consent of the patient concerned, all useful medical information should be communicated to the patient's general practitioner, in order to ensure appropriate medical care.

D. Professional independence

19. Doctors who work in prison should endeavour to provide health care and preventive treatment to prisoners along community lines and be guided in their clinical decisions primarily by the state of health of their patients. The health needs of a detained patient may require special treatment, only available in an outside hospital with the necessary transfer out of the prison. In these circumstances the prison administration must not endeavour to influence the doctor's decision in any way. However, the full responsibility for conducting the patient to the outside hospital rests entirely with the prison authority who must organise the appropriate security arrangements.

20. Medical and nursing staff should be in a position to carry out their professional activity in prison on the sole basis of medical criteria, despite the fact that they also need to take into account the security requirements proper to any prison. The independence of health care staff working in prisons may be guaranteed, for example, by their attachment to the health care services for the general public or supervision by an independent, recognised health authority (professional association, university body, etc.).

21. This professional independence should be accompanied by regular control of the quality of the prison medical service by a competent health authority. Furthermore, sufficient funding should be allocated to the prison health service to enable it to carry out its mission in accordance with the objectives it has been given. The use of an independent, recognised authority to ensure adequate management of funds allocated to the prison medical service is also an important factor in guaranteeing that prisoners are provided with high quality medical services.

22. In order to achieve a reasonable choice of competent doctors who would be capable of working in the special environment of prison, it is important that the level of remuneration should not be lower than that which can be earned in other sectors of public health. This will be a guarantee that the standards in health care available in prison will not decline.

**II. The specific role of the prison doctor and other health care staff in the context of the prison environment**

A. General requirements

23. The prison doctor's primary role is to be the general practitioner of all prisoners, complying with the principles laid down in the preceding paragraphs. However, account should be taken of two important limiting factors in this task of the prison doctor.

First, prisoners' lack of freedom of choice as regards their doctor (unless they seek a second medical opinion) and the prison doctor's contractual duty to treat all prisoners without exception, as his or her mandate is a mission of public interest.

Secondly, constraints resulting from security requirements specific to the prison and the possible demands of judicial proceedings introduce a “triangular” dimension into the usually bilateral relationship between doctor and patient, as both have to take into account the requirements imposed by the third partner (prison administration, the courts) who also has a public interest mission (satisfactory conduct of judicial proceedings in accordance with the relevant statutory provisions, enforcement of a custodial sentence under adequate security conditions in relation to the dangerousness of some prisoners, the risk of escape, etc.).

Given the special context of prisons, where a large number of people are brought together in a small geographical area, the doctor and other health care staff also have a public health mission, that is to take care not only of the individual health of each prisoner, but also of the health of the whole prison community. This mission is particularly important now as most member states of the Council of Europe are confronted with considerable overpopulation in prisons with the risks inherent in such a situation (inmate violence, risk of spreading transmitted diseases, etc.). From this point of view, health care staff must therefore also be attentive to hygiene, food, the minimum space available to prisoners, etc.; if one or other of these criteria is not fulfilled, the doctor has a duty to inform the competent authorities in order that they may remedy the situation.

24. The governor of the prison is ultimately responsible for the health and welfare for all the inmates under his or her care. For this purpose he or she may well seek guidance from various authorities including environmental health officers, community physicians, dieticians and sanitary engineers. However the prison doctor is required to advise the governor on a personal basis in order to co-ordinate health care policy in all these separate fields.

25. Although the respective tasks and competences of health care staff and prison staff are different, or even sometimes conflicting, it is important to maintain constant collaboration and dialogue between the two groups so that health care

staff are able to give advice and make recommendations to the prison management on the handling of delicate situations directly or indirectly related to prisoners' individual and/or collective health. The health care staff may also take part in training prison staff so that the latter acquire general knowledge about health and are able to adopt appropriate attitudes in situations where health factors have to be taken into account (appropriate behaviour when dealing with prisoners with transmissible diseases, appropriate management of crisis situations involving prisoners suffering from a psychiatric illness, etc.).

B. Information, prevention and education for health

26. In conjunction with other information which each prisoner receives on commencing his or her period of custody, further details concerning the medical service and access to the doctor should be made absolutely clear to the detainee. Such information must be complete and precise, and needs to be explained carefully to those prisoners who are illiterate; this particular group will benefit from the use of audio-visual instructional material.

27. In view of the large number of newly arrived prisoners who have neglected their general health and failed to seek medical advice, their entry into custody should provide an excellent opportunity for health care workers to give individual counselling concerning their medical problems. This represents the most important indication for developing a health educationa programme in all prison establishments.

28. Opportunity should be made available to all incoming prisoners to receive, in private, advice concerning infectious ailments which may have been acquired prior to entry into the prison. In this perspective voluntary screenings for such diseases as hepatitis, sexually transmitted diseases, tuberculosis or infection with HIV are required. Such screening programmes should be followed by appropriate counselling in order to inform the patients as to the results of such tests and the medical actions that must now be advised.

29. Such educational and screening programmes have the dual objectives of instilling into the inmates the importance, not only of improving their own health, and as a result of their self esteem, but also to encourage them to take due regard of their lifestyle after release with ultimate benefit to their families.

C. Particular forms of pathology and preventive health care in prison

30. Prison health care services may help prevent violence against prisoners by systematically recording injuries and if necessary, regularly transmitting general information to the competent authorities concerning the problem of violence in prison. This approach contributes directly to promoting human rights and is perfectly in accordance with the purpose of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. It is useful not only for making amends to victims of violence, but also and especially for the part it can play in preventing the unjustified use of violence.

31. When a prisoner alleges violence, the prison doctor should carry out a detailed medical examination, and then exhaustively record all injuries observed, as well as all the supplementary examinations carried out (x-rays, specialised examinations, etc.); the doctor should also note any treatment prescribed. After such a medical examination, there are two possibilities, namely:

– transmission of a detailed medical report to the competent authority, with the victim's consent;

– the systematic recording of every medical observation made after allegations of violence, in order to transmit regularly anonymous and comprehensive statistics to the competent authority.

32. In the interest of the prisoner and/or the prison community as a whole, the doctor may inform the prison management of a serious incident that represents a real danger, with a view to preventing violence and protecting individuals. In this eventuality, the consent of the victim appears to be less essential than the public interest. The health care service should collect, if appropriate, periodic statistical data concerning injuries observed, with a view to communicating them to the prison management and the ministries concerned, in accordance with national legislation on data protection. This procedure would have the advantage of preventing further aggressive behaviour and outbreaks of violence. Such information might also be used as evidence in proceedings concerning violence against persons in police custody and thus exercise a deterrent effect in this connection.

33. The prison management and staff are often the first to be affected by the detection of prisoners exhibiting behavioural disturbances, sometimes characterised by hetero-aggressive, violent attitudes resulting from psychiatric problems (psychotic pathologies, depression). The prison doctor and other health care staff can play an important role by regularly providing custodial staff with training and advice so as to facilitate the management of any “crisis situations” involving prisoners suffering from mental illnesses. Accordingly, the cardinal importance of regular collaboration between custodial and health care staff must again be emphasised, as a co-operative approach can make for early diagnosis and better treatment of prisoners suffering from psychiatric illnesses.

D. The professional training of prison health care staff

34. The health care staff in any prison may be confronted with professional situations which are delicate in terms of medical ethics and patient's rights (refusal of treatment by a prisoner able to understand, conflict between respecting confidentiality and protecting the interests of the prison community, etc.). Consequently, both prison doctors and other

health care staff need sufficient professional training that takes into account the special characteristics of medical practice in prisons (general knowledge of public health to ensure an appropriate approach to the health problems of a community dominated by overcrowding, some knowledge of psychiatry and addiction to drugs, alcohol or medication, but also a general understanding of the prison context and its likely effects on the state of physical and mental health of inmates, etc.).

35. Health care staff working in prisons should therefore, wherever possible, be provided with in-service professional training and have access to other continuing training programmes (vocational schools, universities, etc.). Such training could also include the acquisition of knowledge of the functioning of prisons, of relevant prison regulations and of national and international standards for prison management and the treatment of offenders. Such training could help prison health care staff obtain recognition of their professional speciality by their respective authorities, thus strengthening their identity as prison health care workers, as well as the quality and special nature of work carried out in prisons. This applies in particular to prison nursing staff who, for a long time, were recruited from among warders and received brief health training, mainly during their work in prison. The tendency now is to gradually reduce this category of paramedical staff in favour of qualified nursing staff with full professional training in general or psychiatric nursing.

**III. The organisation of health care in prison with specific reference to the management of certain common problems**

A. Transmitted diseases, in particular: HIV infection and Aids Tuberculosis Hepatitis

36. It is well known that sexual activity between inmates occurs in prison and likewise it is evident that a significant percentage of persons taken into custody are already infected with sexually transmitted diseases. Under these circumstances, appropriate prophylactic measures should be taken. These might involve in certain cases the provision of condoms to inmates, in accordance with national legislation and practice.

37. As regards HIV infection and Aids, the same principles should be applied and reference should in particular be made to Recommendation (93) 6 of the Committee Ministers concerning prison and criminological aspects of the control of transmissible diseases including Aids and related health problems in prison. In view of the often irrational fears and reactions aroused by this infectious disease, it is essential that the voluntary nature of HIV screening and the confidentiality of the result of the examination be respected. Any exception to the voluntary nature of screening should be made only in accordance with the law.

38. Patients suffering from an infectious disease should be isolated only on the basis of medical criteria (risks of infection) which should be applied in prison in exactly the same way as in the community as a whole. This principle of non-discrimination is recognised and affirmed in several international texts and is a fundamental aspect of protecting and promoting human rights. Furthermore, the isolation of a person with a contagious disease should take place in accordance with the law and in conditions that take account of the special characteristics of the prison environment.

39. The isolation of people who are HIV positive should be based only on medical criteria; in particular, an HIV positive prisoner who has no manifestation and/or complication of this viral infection (an individual in good health generally known as a “healthy carrier”) should have access to all the activities and workplaces offered in prisons.

40. Prisoners who are HIV positive or have Aids should receive regular medical check-ups and have access to preventive treatments (prophylaxis for pneumocystis carinii, pulmonary infection and cerebral toxoplasmosis; possible vaccinations). The medical management of such patients may best be undertaken by a consultant in infectious diseases, in view of the highly specialised knowledge required in the evaluation and treatment of these conditions. Patients seriously ill with Aids should be given the appropriate care by the prison health service and, if necessary, be transferred to a hospital unit for prisoners; the great fluctuations observed in the natural development of this illness should be taken into consideration when choosing and fitting out accommodation for the sick prisoner. Basing choices exclusively on medical criteria and/or taking account of prisoners' wishes are the best guarantees of preventing any discrimination against people infected with HIV or suffering from Aids. In addition, when a prisoner is at an advanced stage of Aids, the prison doctor should, in agreement with the patient concerned, draw up a detailed medical report for the attention of the competent authority, so that it may take a decision as to the appropriateness of keeping him or her in prison. However, where patients become seriously ill with Aids-related illnesses and are likely to acquire additional infections, their isolation might be appropriate. They should receive the fullest information possible about the medical grounds for, and the probable benefits of, such a measure.

41. In all cases of tuberculosis, the medical services of the local chest physician should be requested in order to obtain the long-term advice that is required for the treatment of this condition as is undertaken in the community in accordance with relevant legislation.

42. In the field of health promotion and education for inmates, the significance of an effective method of preventing the spread of hepatitis B and C should be emphasised in the perspective of the risks associated with needle contamination and sexual activity. In the case of the prevention of hepatitis B, the importance of a vaccination programme should be stressed to all inmates and staff.

B. Addiction to drugs, alcohol and medication

Management of pharmacy and distribution of medication

43. There are differences in the treatment of drug addicts in the various member states of the Council of Europe. Whether it is a matter of outpatient therapy or residential treatment in specialised institutions, there are different approaches to the management of drug addiction, and these approaches are modulated in each member state by the relative severity or permissiveness of the legislation on drug use in force. Given this objective observation, the essential principle that should be applied for medical treatment of addicted prisoners is that of equivalence with the therapeutic practices prevalent in the country concerned. Therefore, the care of prisoners with drug and alcohol-related problems needs to be developed further.

44. The proportion of the prison population addicted to drugs is much higher than that of the general public. This is the result not only of legislation against drug use and drug trafficking, but, above all, of secondary offences – mainly against property – committed by addicts in order to procure the income necessary to buy drugs for their own use. Given this fact, it is essential to provide drug addicts in prison with adequate medical and social assistance to enable those who are serving long sentences to take part in counselling and rehabilitation programmes which continue after release, so as to facilitate their social reintegration and avoid a return to marginalisation, with the serious risk of relapsing into illegal drug use. Accordingly, psychotherapeutic and medico-social programmes developed in prisons should be closely linked to the approach used in the community as a whole with regard to drug-dependent people (drugs, alcohol, medication).

45. The treatment of the withdrawal symptoms of abuse of drugs, alcohol or medication in prison should be conducted along the same lines as in the community. For example, concerning drug addiction, it is possible to use either “classic” therapeutic approaches based on rapid withdrawal of drugs from addicts entering prison or, on the other hand, maintenance therapy using methadone. Thus, if a prisoner has been undergoing maintenance therapy using methadone before imprisonment, and will be in prison for only a short time, it is important to continue appropriate therapy in prison so as to guarantee that satisfactory treatment continues after release, and this may help reduce the risk of the person relapsing into illegal drug use.

46. Among the necessary steps to avoid a relapse into addiction, it may be helpful to create so-called “drug free” accommodation in selected areas of the prison where the inmates have consented to withstand the temptation to revert to their habit and purchase illegal drugs. Under these circumstances, the prisoners sign a “contract” which binds them to remain free of drugs and willingly provide urine specimens on random occasions for the purpose of testing for drug taking. If the result is negative, the assumption is that the inmates are anxious to avoid a relapse. These steps should encourage them to improve their lifestyles on release.

47. The full integration between specialist counsellors within the prison and the appropriate services in the community will enhance the smooth transfer from prison to home, after which continued care can be ensured by outside agencies.

48. The management of the pharmacy and the distribution of medication in prisons was in the past often carried out by people with no specific recognised qualifications and prescribed medication was only exceptionally carried by sick prisoners: they had to go to the prison medical service to receive their individual treatment, oral prescriptions usually being administered in liquid form (diluted medication). Behaviour and practices have, however, changed in many countries and there is a trend of issuing to the patients concerned only those medicines dose by dose that may be dangerous when taken in excessive doses. With psychologically stable prisoners, giving the doses of the necessary medicines directly to the patients may sometimes have good results and make the patients responsible as, when they leave prison, they will have to seek a prescription made out by their doctor and go to a pharmacy to collect the medicines prescribed. Such an approach aims once again to satisfy the principle of equivalence with the practice in the community at large and also helps patients to take responsibility for their illnesses.

49. In view of the very great quantity of medicines now available on the market, the prison doctor may make a list of the medicines usually prescribed by the medical service, in consultation with a pharmaceutical adviser, so as to favour the criteria of therapeutic efficacy and economy, while at the same time responding adequately to the health needs of the prison community. The prison doctor and nursing staff should keep themselves regularly informed about new pharmacological and therapeutic developments.

C. Persons unsuited to continued detention: Serious physical handicap; advanced age Short term fatal prognosis

50. Generally, there are few prisoners with serious physical handicaps or of advanced age. However, to comply with paragraph 1 of the European Prison Rules, which states that “deprivation of liberty shall be effected in material and moral conditions which ensure respect for human dignity”, appropriate provision should be made for conditions compatible with the use of a wheelchair, assistance with usual daily activities, etc.). Prisoners suffering from a medical condition with a short-term fatal prognosis should be provided with medical care appropriate to their state of health, in particular by transfer to a hospital unit especially designed for prisoners.

51. For the purpose of considering the possibility of a pardon for medical reasons or early release the prison doctor may, with the sick prisoner's consent, draw up a medical report describing his or her state of health for the competent authority. This approach may be used with respect to prisoners in the terminal phase of Aids, in compliance with international recommendations and directives on the subject, such as Recommendation (93) 6 concerning the prison and

criminological aspects of the control of transmissible diseases including Aids and related health problems in prison, or the World Health Organisation Guidelines on HIV Infection and Aids in prisons.

D. Psychiatric symptoms

Mental disturbance and major personality disorders

Risk of suicide

52. Psychiatric symptoms and mental disturbance are common in prisoners and may be a reaction to deprivation of freedom, as this breaks off family contacts and may give rise to fear of other prisoners, compounded by reactive anxiety. To be able to manage these problems the prison doctor and nursing staff need extra qualifications that they may acquire through appropriate training and experience. The prison administration and the ministry responsible for mental health should co-operate in organising psychiatric services for prisoners. In addition, it is important for the prison medical service to have the support of psychiatrists and psychologists, either part or full-time, according to the size of the prison population. Group therapy organised by competent therapists also plays an important part. This measure is also indispensable for identifying people with serious mental illness among the many prisoners who are undergoing a life crisis and are suffering from an unacceptable level of stress.

53. In the prison environment different services provide care and assistance for inmates. These services cannot be seen as completely separate from one another. This applies in particular to the mental health service and the various social services in prison whose aims are widely similar: they include in particular helping prisoners to adapt to the prison environment, assisting them in tackling personal and social problems or providing help in stress situations which might arise during detention and, very frequently, prior to release (i.e. anxiety concerning such matters as re-establishing proper family relationships, making provision for work and housing, etc.). In view of the fact that, despite their specific areas of competence and expertise, the aforementioned services share important objectives in relation to the treatment of offenders, they should co-ordinate their activities in order to offer prisoners integrated counselling and assistance. Such co-operation should be respectful of the professional independence of the experts involved.

54. In cases of convicted sex offenders, the associated problems are extremely complex and very often totally resistant to treatment. It is frequently necessary to resort to long-term confinement in order to protect the outside community. Such confinement should be accompanied by appropriate treatment during the offender's stay in a penal institution and after his or her release.

55. In accordance with the principle of equivalence, every prisoner suffering from a serious mental disturbance should receive appropriate medical treatment as an outpatient and/or in hospital. As far as hospital treatment is concerned, two options may be envisaged according to health policy trends. On the one hand, it is often argued that from an ethical standpoint, mentally ill prisoners should be hospitalised outside the prison system, that is in a medical establishment that is part of the health system for the general public, in order to favour access to appropriate psychiatric hospital treatment. On the other hand, the existence of a psychiatric hospital unit in a prison also makes it possible to give treatment in optimum security conditions and to intensify the activities of the medical and social services within the prison system.

56. When nursing staff are unable to control a violent mentally ill prisoner, it may be necessary to call on the custodial staff for assistance, in so far as the restraint remains in proportion to the objective to be achieved, that is cessation of the violent behaviour and institution of appropriate therapy. With this in view, it may be necessary to locate the agitated mentally sick prisoner in an isolation cell with regular medical and nursing care, until his or her disturbed behaviour is under control.

57. Physical restraint may only be resorted to in exceptional circumstances when no other therapeutic means is likely to obtain the desired result (principle of proportionality). Such restraint of a patient should be carried out under continuous medical supervision, for as brief a period as possible, until the effects of appropriate medication have begun to calm the patient; physical restraint should never be used as a punishment. However, this measure should be regarded as the exception rather than the rule, since the care of a mentally ill patient implies that “in all circumstances, the patient's dignity should be respected” (Article 10 of Recommendation (83) 2 of the Committee of Ministers concerning the legal protection of persons suffering from mental disorder placed as involuntary patients). In this respect, it should be remembered that any derogation from the principle of free consent to medical treatment by a prisoner suffering from mental illness must comply with the law and be applied in the same way as in cases provided for the community as a whole.

58. The placement of a prisoner suffering from a mental illness in an isolation cell may apply by analogy to prisoners presenting a risk of suicide. Medical treatment should always be in proportion to the objective seriousness of the particular case and, if appropriate, medium- or even long-term therapy should be arranged.

59. It is essential that the prison doctor has ample notice of the forthcoming release of his patient in order that he may arrange an outside appointment with all the supportive services very shortly after leaving prison. It should be ensured that all necessary documentation is dispatched to the providers of such services with the full consent of the patient.

E. Refusal of treatment

Hunger strike

60. According to the principle of respect for free consent to medical treatment, any prisoner able to understand may refuse a diagnostic or therapeutic medical act. Where this happens, the following measures could be envisaged:

– after appropriate assessment, indicate in the medical record that the patient is able to understand;

– inform the patient of the consequences of his or her refusal for his or her state of health and examine any possible therapeutic alternatives; at this stage, when the patient should be provided with full, detailed information, it must be ensured that he or she is able to understand all the information given and if there is any linguistic barrier, the doctor should seek the services of an interpreter;

– record the patient's refusal in his or her medical file in the presence of a witness (doctor or nurse, for example);

– ask the patient to sign a document absolving the doctor of liability; if he or she refuses, this fact should be noted in the presence of a witness and recorded in the patient's medical file;

– remind the patient that he or she may change this decision at any time.

61. The term “hunger strike” usually refers to voluntary failure to eat and amounts to self-destructive behaviour by an individual in conflict with the courts, the prison authorities or the police. Accordingly, a prisoner on hunger strike may only be medically examined with his or her consent. Initial medical assessment is, however, indispensable in order to identify the presence of a possible psychiatric pathology at the root of such self-destructive behaviour as, in such cases, the prison doctor should then take all appropriate therapeutic measures likely to improve the prisoner's mental pathology.

62. If the prisoner is on hunger strike and the medical assessment reveals nothing compatible with a psychiatric disorder, the prison doctor should, with the consent of the person concerned, undertake regular medical and para-medical check-ups (checking weight, key parameters, blood test, etc.), so as to inform the prisoner of the progressive deterioration of his or her state of health connected with failure to eat.

63. If necessary, the prison doctor should transfer the prisoner concerned to hospital, in order to strengthen medical observation. In addition, a prison doctor who considers that the health of a prisoner on hunger strike is deteriorating significantly, should regularly inform the competent authority about the changes in the patient's health.

F. Violence in prison

Disciplinary procedures and sanctions

Disciplinary confinement; physical restraint

Top security regime

64. Incidents of violence among prisoners are a permanent challenge to prison management and staff. Numerous factors have been identified as contributing to the emergence of violence, such as prison overcrowding, the heterogeneity of the prison population in terms of their cultural, religious or ethnic origin, the presence of particularly problematic prisoners or specific categories of inmates who are likely to trigger off hostile reactions from their fellow-inmates, etc. (in particular sex offenders, child molesters, etc.). Despite the fact that much can be done in order to reduce the level of aggressiveness in prison (specific psycho-social programmes; improving communication, etc.) certain prisoners who are particularly exposed to becoming targets of violent acts on behalf of other prisoners might require specific protection on a short-term or even a long-term basis. Appropriate arrangements for the safety of such prisoners should therefore be made. Among such measures are the provision of individual cells, the creation of special confinement sections or increased surveillance by custodial staff.

65. The role of the prison doctor and nursing staff does not include controlling violent or very aggressive prisoners or deciding disciplinary sanctions to be imposed, including solitary confinement. The security staff is responsible for maintaining order and discipline in the prison and the role of the prison health care staff does not under any circumstances involve authorising or approving the possible use of force against prisoners, since this is the role and responsibility of the prison security staff.

66. As a matter of principle the decision to impose a disciplinary sanction on a prisoner, including disciplinary confinement, or to have recourse to specific security measures (eg. transfer of an inmate to a special prison unit) rests with the prison management. Doctors should not become involved in such a decision. However, the prison doctor should provide the necessary medical treatment or assistance to prisoners who are subject to such disciplinary measures or a special security regime on request of the prisoner or members of the custodial staff.

G. Health care special programmes:

Sociotherapeutic programmes

Family ties and contacts with the outside world

Mother and child

67. Prisons are often far removed from the role of “corrective” institutions and public opinion does not always hold them in high esteem. Furthermore, most member states of the Council of Europe are faced with considerable overcrowding in

their prisons. The surplus of prisoners tends to turn prisons into hostile environments where many individuals are in contact with serious offenders and become familiar with criminal behaviour – situations which carry within them the seeds of reoffending. In this context, socio-therapeutic programmes are of great importance in a modern penal system. Programmes organised along community lines can reduce prisoners' feelings of humiliation, self-contempt and hatred, give them a feeling of responsibility and prepare them for appropriate reintegration in society. All these measures help promote and maintain a satisfactory state of physical and mental health in prisoners, which is why the prison health care staff should, as far as they are able, be involved in this type of socio-therapeutic treatment. Another direct advantage of such programmes is that they call for the active participation and involvement of prison officers. As prison doctors often have an intimate knowledge of the persons in their care they might be well placed to encourage them to actively participate in sociotherapeutic and other special educational programmes. For this purpose, doctors would need to keep themselves abreast with the contents and operation of such programmes and co-operate constructively with the services and professionals concerned.

68. The policy concerning sexual encounters between prisoners and their partner calls for difficult decisions and varies from country to country. In many cases such measures may help married prisoners to maintain family ties and meet in particular the sexual needs of long-term prisoners. Where these facilities are being provided, it should be ensured that the inmates can meet their sexual partner without visual supervision.

69. Mothers and children, like seriously ill, disabled and very old prisoners, may be regarded as a “particularly vulnerable” group in prison. The prison doctor and other health care staff should therefore ensure the best possible care for mother and child, taking into account in particular the interests of the child and the living conditions arranged for mother and child in the prison. Those children who live with their mothers in prison should be able to leave the prison freely in order to visit their families living outside.

70. The reinforcement of the maternal bonding will be very much enhanced by organising the provision of crèches, day-nurseries and kindergartens and this will often prove of value to the mother when she returns to take her maternal place in her family on release. While there are great variations in member states of the Council of Europe as regards the age at which a child in prison with its mother is separated from her, it is recommended that such a decision be taken by the competent administration or authority in the light of appropriate paedo-psychiatric and medico-social opinions.

H. Body searches

Medical reports

Medical research

72. Body searches are carried our for security reasons, not for medical purposes; body searches of prisoners cannot therefore be regarded as medical acts. Consequently, neither the prison doctor nor the other health care staff of the prison should be involved in this type of procedure. This view is in accordance with the Declaration of the World Medical Association (WMA) on body searches of prisoners (1993). Accordingly, the prison doctor should only conduct an intimate examination when there is an objective medical reason requiring his or her involvement (pregnant woman, rectal or anal pathology, for example). Furthermore, intimate examination, which in these circumstances is a specialised act, should as far as possible be carried out by a doctor other than the prisoner's usual doctor. On the other hand, if a prisoner asks the doctor to perform an intimate examination in order to convince the security staff that his or her body is not concealing any hidden object, the doctor should refuse the request if there is no objective medical reason for it.

73. As a rule, a clear distinction should be made between the role of a prison doctor and the role of a medical expert called to assess the physical or mental state of an offender within the framework of criminal proceedings or, for instance, in relation to decisions on early release. The prison doctor works in a context where it is particularly difficult to build a relationship of trust with imprisoned patients (no freedom of choice of doctor, “triangular” relationship between doctor and patient resulting from the prisoner's dependence on the judicial or administrative authority, etc.). The purpose of this work is, by its very nature, different from the work carried out by a medical expert who might often be perceived by the offender as an agent of the criminal justice system. Given the specific nature of the prison context it is appropriate for the prison doctor to avoid any doubt about his or her role as provider of health care. It is also appropriate that medical decisions be made solely in the interest of the health and well-being of the inmates. This also involves, for example, abstaining from collecting and analysing specimens for other purposes than diagnostic testing. However, under exceptional circumstances, a prisoner might wish that his or her doctor accept a mission as medical expert in a judicial procedure. The doctor should accept such a task only on formal request by the prisoner and after informing him or her about the likely implications of this task, or following a decision by a court.

74. This paragraph recalls basic principles for medical research as expressed in Recommendations (87) 3 on the European Prison Rules (Rule 27), (90) 3 on medical research on human beings (principle 7) and (93) 6 on prison and criminological aspects of the control of transmissible diseases including Aids and related health problems in prison (paragraph 16). In order to properly implement these principles, the following safeguards should apply: informed and written consent by the prisoner should be obtained, which should imply that the prisoner is not induced to participate by prospect of any privileges; the possibility to withdraw this consent at any time; and the approval of the procedures by an appropriate ethical committee independent of both the doctor carrying them out and the prison authorities, in conformity with national legislation.

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(1) Les mots de la bioéthique by G. Hottois and M.-H. Parizeau, Collection Sciences, Ethiques, Sociétés; De Boeck University, Brussels, p. 117 ff.

(2) Among the most important texts of the WMA in this area are: the Declaration of Geneva (1948), the Declaration of Helsinki (1975) and the Declaration of Lisbon on the rights of the patient (1981).

(3) The WMA has also drawn up texts more specifically affecting the sphere of activities of health care staff in prisons, such as the Statement on body searches of prisoners (1993), the Resolution on physician participation in capital punishment (1981), the Declaration of Malta on hunger strikers (1991) and the Declaration of Tokyo (1975).

(4) Third general report on the CPT's activities covering the period 1 January to 31 December 1992.