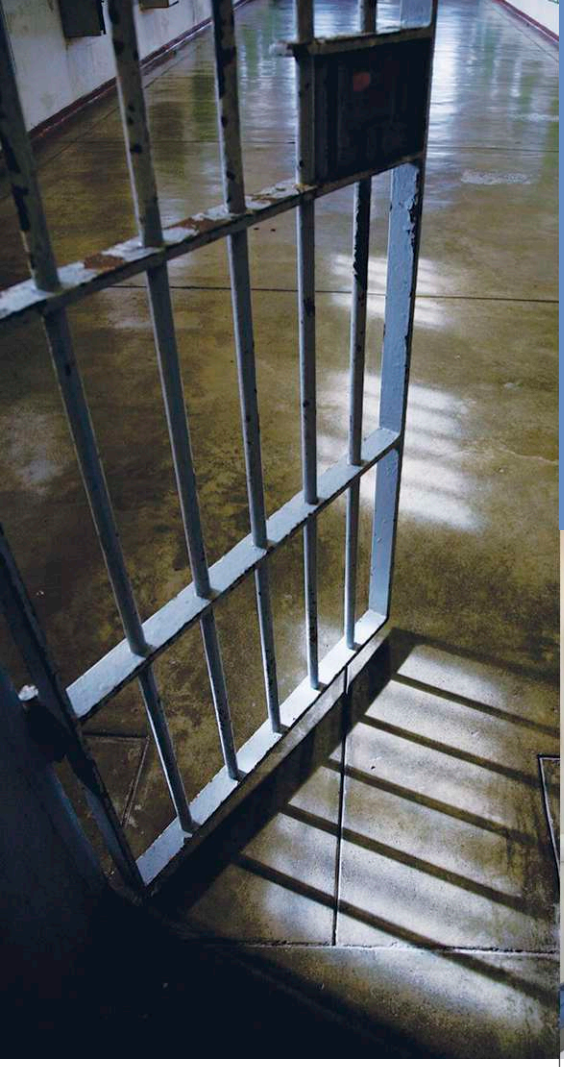

Prison health care and medical ethics

A manual for health-care workers and other prison staff with responsibility for prisoners' well-being

Andres Lehtmets
Jörg Pont

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The authors

Mr Andres Lehtmets, Psychiatrist, West Tallinn Central Hospital, Estonia, former Vice-President of the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment

Mr Jörg Pont, former Medical Adviser to the Ministry of Justice of Austria

Contents

Foreword

This manual is addressed to prison health-care workers and other prison staff with responsibility for prisoners' well-being. It provides practical information about a range of issues related to psychiatric care, prevention of the spread of transmissible diseases (such as acquired immunodeficiency syndrome, hepatitis and tuberculosis), psychoactive drugs and the medical management of drug-addicted prisoners. The text highlights important ethical standards and suggests responses to ethical dilemmas related to access to a doctor, equivalence of care, patient's consent and confidentiality, preventive health care, humanitarian assistance, professional independence and competence.

This manual contains good practice from across Europe. The authors have drawn on the results of a multilateral meeting on medical ethics and health-care in prison held in Strasbourg in May 2012. At that meeting, senior officials and professionals responsible for health care in prison from several Council of Europe member states shared their experiences and discussed ways of applying in practice Council of Europe standards and the recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

The manual is conceived as a comprehensive policy guide and a management tool. It will be used as training support in the technical co-operation activities of the Council of Europe. Health-care services for persons deprived of their liberty are directly relevant to the CPT's mandate. Inadequate health care can lead rapidly to situations of inhuman and degrading treatment, whereas medical and non-medical staff in prisons with better professional knowledge and skills mean a healthier and safer environment for prisoners and prison staff and better protection of the public by reducing the risks of transfer of health problems from prisons to the community.

I would like to thank the authors, Mr Andres Lehmets, psychiatrist in West Tallinn Central Hospital in Estonia, former Vice-President of the CPT, and Mr Jörg Pont, former Medical Adviser to the Ministry of Justice of Austria, whose excellent professionalism and long experience are reflected in this manual. I also thank my colleagues Luljeta Kasa and Tanja Rakusic-Hadzic whose efforts made this publication possible.

Philippe Boillat
Director General
Directorate General
Human Rights and Rule of Law
Council of Europe

List of abbreviations

CDC	Centers for Disease Control and Prevention (USA)
CM	Committee of Ministers of the Council of Europe
CPT	European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders (APA, 1994)
ECHR	European Convention of Human Rights
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPR	European Prison Rules
ICD-10	International Classification of Diseases, version 10 (WHO, 2010)
ICRC	International Committee of the Red Cross
NICE	National Institute for Health and Clinical Excellence
TBCTA	Tuberculosis Coalition for Technical Assistance
UNAIDS	Joint United Nations Programme on HIV/Aids
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
WMA	World Medical Association

Chapter 1

Medical ethics in prison

Health care in prison is guided by the same ethical principles as in the community. The basic principles are set by the World Medical Association Declaration of Geneva (1948, latest version in 2006), the International Code of Medical Ethics (1949, latest revision in 2006),[1] United Nations General Assembly resolution 37/194 (of 18 December 1982) and Recommendation No. R (1998) 7 of the Committee of Ministers of the Council of Europe of 8 April 1998[2] on the ethical and organisational aspects of health care in prison.

The primary task of a prison doctor and other health-care workers is the health and well-being of the inmates. Respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care, both equivalent to those provided to the community.

Health-care services for persons deprived of their liberty are also directly relevant to the prevention of ill-treatment. An inadequate level of health care can lead rapidly to situations falling within the scope of the term "inhuman and degrading treatment".[3] Obliging prisoners to stay in an establishment where they cannot receive appropriate treatment due to lack of suitable facilities, or because such facilities refuse to admit them, is unacceptable. A violation of Article 3 of the European Convention of Human Rights (ECHR) was found by the European Court of Human Rights in several such situations.[4]

1. WMA Declaration of Geneva (1948); WMA International Code of Medical Ethics (2006).
2. 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); CM: *The ethical and organisational aspects of health care in prison*. Recommendation R (1998) 7.
3. The European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT) Standards 2002 (rev. 2011).
4. *Khudobin v. Russia* 59696/00, *Mouisel v. France* 67263/01, *Kaprykowski v. Poland* 23052/05.

1.1 Levels of health-care services in prison

It is obvious that the prison itself cannot cater for all the possible health-care needs of prisoners. This is particularly true of specialist services. Health-care services that cannot be provided in prison should be arranged in co-ordination with nearby community hospitals. The substantive section of the 3rd General Report of the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT) outlines the organisation of health-care services in a prison setting.[5] Health-care services in prison should, as a minimum, be able to provide:

- regular general practitioner and specialist consultations,
- supervised outpatient treatment,
- dental care,
- an infirmary,
- direct support of a fully-equipped service from either civil or prison hospital,
- interventions for emergency situations.

There is a growing trend of integrating prison health care into community health-care services. This development has been seen as a step in the right direction by the Council of Europe. When the prison health-care service relies on specialist care from providers outside the prison, the availability of these services may become an issue. The prison service needs to make sure that the working times and qualifications of attending physicians meet the prison's needs. The presence of nursing staff should make it possible to provide all necessary nursing care. For example, medication should preferably always be distributed by nursing staff. If that is not possible, the authorities should at least draw up a list of medication that must always be distributed only under the supervision of the medical staff, such as psychotropic and antiviral medication as a minimum. In cases when there is no medical staff available on the premises, at night-time and weekends, the staff should be trained in providing first aid. As a rule, a doctor should be on call for emergency situations.

5. CPT/Inf (2012)21.

Equivalence of care

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 care, in conditions comparable to those provided to patients in the community. Provision in terms of medical, nursing and technical staff, as well as premises, installations and equipment, should be geared accordingly.

Treating prisoners in civil hospitals

As mentioned above, the prison itself cannot always guarantee all the specialist care needed. Nearby hospitals often have to be used to find a solution for more difficult medical problems. In case of recourse to a civil hospital, the question of security arrangements will arise. Prisoners sent to a hospital to receive treatment should not be physically attached to their hospital beds or other items of furniture for custodial reasons. Other means of meeting security needs satisfactorily can and should be found; the creation of a custodial unit in such hospitals is one possible solution.[6]

1.2 Hygiene and health promotion

The task of a prison health-care service should not be limited to treating sick patients. In the absence of a specialised service, it is also their responsibility, in co-operation with competent authorities, to supervise catering arrangements (quality, quantity, preparation and distribution of food) and conditions of hygiene (cleanliness of clothing and bedding, access to running water, sanitary installations) as well as the heating, lighting and ventilation of cells. Work and outdoor exercise arrangements should also be taken into consideration. Prison medical services should also cover mental hygiene, especially preventing the harmful psychological effects of certain aspects of detention. Unhealthy conditions, overcrowding, prolonged isolation and inactivity may necessitate either medical assistance to individual prisoners and/or general medical action by the responsible authority.[7]

6. CPT/Inf (2012)13.
7. CPT/Inf (2012)4.

Access to a doctor

While in custody, prisoners should be able to have access to a doctor at any time, irrespective of their detention regime. This is of particular importance when the person has been placed in a solitary detention regime. The health-care service should enable requests to consult a doctor to be met without undue delay. Outpatient treatment should be supervised by the health-care staff; in many cases it is not sufficient that the provision of follow-up care depends on a request by the prisoner. Follow-up medical treatment should be planned accordingly.

Access to medication

Medication should be provided to prisoners according to their state of health. The principle of equivalence of care applies in such a case as well. The funds allocated to prisons should be sufficient to enable medication to be provided free of charge to prisoners who are not covered by medical insurance or do not have the resources to pay for it themselves. There should be no interruption (in cases of transfer from one establishment to another) to ensure the continuity of long-term treatments.[8]

1.3 Medical confidentiality

With the exception of emergencies, every medical examination/consultation should be performed in a medical consultation room, in order to create an atmosphere of confidence, confidentiality, privacy and dignity. Medical confidentiality should be guaranteed and respected with the same rigour as for the population as a whole. Prisoners should be examined individually, not in groups. No third non-medical persons (other prisoners or non-medical staff) should be present in the examination room. Prisoners should not be handcuffed during examination/consultation and security officers should stay out of earshot and out of sight during the physical examination, unless the doctor or nurse requests otherwise on grounds of safety and security.[9] In several recent CPT country visit reports, practices not complying with these rules have been criticised.[10] The European Court of Human Rights found a violation of Article 3 of the ECHR – that is, inhuman and degrading

8. CPT/Inf (99)18.
9. CPT Standards 2002 (rev. 2011).
10. CPT/Inf (2007)47; (2008)3; (2010)1; (2011)20; (2012)17; (2012)32.

treatment[11] – in cases of handcuffing of prisoners during medical examination and treatment.

Alternative solutions can and should be found to reconcile legitimate security requirements with the principle of medical confidentiality. One possibility might be the installation of a call system, for a doctor to be in a position to rapidly alert prison officers in those exceptional cases when a prisoner becomes agitated or threatening during a medical examination.[12]

The final decision, on ethically questionable practices regarding the use of handcuffs and interviews behind glass, should be left to the medical staff. Examination rooms should be secure, so they must be fitted out in such a way as to limit risks of escape; this also helps to meet security concerns.

If and when the custodial staff are trusted to distribute medication to prisoners, the medical staff should pre-pack medication in dosette boxes. In order to preserve medical confidentiality, the staff distributing medication should not be aware of the names and dosage of the medication.

Keeping prisoners' medical files is the responsibility of the doctor. In the event of transfer, the file should be sent in a confidential way – using secure data transfer – to the doctors in the receiving establishment.

Doctor–patient confidentiality as a cornerstone of medical ethics

Respect for confidentiality is essential in ensuring an atmosphere of trust, which is necessary for the doctor–patient relationship; it should be the duty of the doctor to preserve such a relationship and to decide how to observe the rules of confidentiality in a given case. A prison doctor acts as a patient's personal doctor. Prisoners should be able to approach the health-care service on a confidential basis – for example, by means of a message in a sealed envelope. Prison officers should not seek to screen requests for consultation with a doctor.

A difficult situation may arise when the patient's decision conflicts with the general duty of care incumbent on the doctor. This might happen when the patient is influenced by personal beliefs (for example, refusal of a blood

11. *Mouisel v. France* 67263/01 and *Tarariyeva v. Russia* 4353/03.
12. CPT/Inf (2007)47.

transfusion) or even resorting to self-mutilation in order to press for a demand, protest against authority or demonstrate support for a cause.

1.4 Medical consultations

In line with CM Rec(2006)2 on the European Prison Rules (EPR), paragraph 42.1-3 (Duties of the medical practitioner), the medical practitioner shall see every prisoner as soon as possible after admission, whenever inmates complain of illness, after injuries or violence and before release. If personally unable to see the new prisoner or prisoner patient in due time, the doctor must ensure that another physician or qualified nurse will stand in.[13] Wherever this is not possible, due to understaffing of health-care personnel and/or overcrowding of prisons, the first of the seven essential principles of the CPT, access to a doctor, would be hampered. It is the responsibility of the health-care staff to claim additional staff if needed and to document this claim. In its country visits, the CPT repeatedly identified in many countries inadequate staffing of health-care personnel in prisons. The sequels of insufficient health-care staffing – lack of, or delays in, medical examinations, consultations or care – can amount to inhuman treatment, a violation of Article 3 of the ECHR.[14]

The patient's consent

As a rule, health-care professionals must not carry out examinations or treatment without the consent of the patient. True consent requires proper information – "informed consent" – which should also take into account illiteracy, difficulties in understanding and language barriers, often found in the prison population, a problem that the CPT has encountered in several country visits. In case of non-consent or refusal, the doctor must make sure that the patient understands the implications of his/her decision and that the patient is informed that he/she can revoke his/her decision at any time. Any derogation from the principle of patient consent is justified only if it complies with the law, for example in the case of those mentally ill patients who do not have the capacity to understand the consequences or in cases of emergency treatment of unconscious patients. Non-compliance with this ethical principle has been found time and again during CPT visits.[15] The European Court of

13. CM: Recommendation Rec(2006)2 on the European Prison Rules (revised).
14. *Pavalache v. Romania* 38746/03; *Khudobin v. Russia* 59696/00, *Hummatov v. Azerbaijan* 9852/05.
15. CPT/Inf (2008)26, (2009)13, (2010)1, (2011)1, (2011)20.

Human Rights found a violation of Article 3 of the ECHR[16] in cases of medical interventions without the consent of the patient.

The right to consent to treatment

Every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be in conformity with the law and only related to clearly and strictly defined exceptional circumstances which are applicable in the community.

A very cautious approach must be followed when it comes to biomedical research with prisoners. There is always a risk that the agreement to participate could be influenced by the penal situation. Safeguards should exist to ensure that any prisoner affected has given free and informed consent. The rules should be the same as those prevailing in the community.

Medical consultation on admission

The importance of the medical examination on admission needs to be emphasised: its main purpose is the early detection of critical health conditions which might require immediate measures to protect the health of the new inmate and, in cases of transmissible diseases, to protect the health of the prison population. This is why this examination, save for exceptional circumstances, should be carried out on the day of admission of the prisoner.[17] Undue delays of medical screening on admission[18] – or their superficial and less-than-comprehensive nature[19] – have been recently found by the CPT in several country visit reports.

In addition, the medical entry examination provides a key opportunity for health-care professionals to gain the trust of the new inmate and to deliver information on:

- health-care professionals' confidentiality and professional independence,
- the rights and responsibilities of inmates regarding health,
- the organisation of health-care services and how, when, where and from whom to receive medical help and advice,

16. *Nevmerzhitsky v. Ukraine* 54825/00; *Jalloh v. Germany* 54810/00.
17. CPT Standards 2002 (rev. 2011).
18. CPT/Inf (2009)38; (2011)20; (2012)17; (2012)32.
19. CPT/Inf (2011)33; (2011)24; (2012)17; (2012)34.

- the risk from transmissible diseases in prison and how to avoid it,
- screening examinations for tuberculosis, HIV and hepatitis B/C infections,
- any special treatment and health-promotion programmes provided in the prison.

This information should be provided in a way that the prisoner can fully understand. Important consideration should be given to learning disabilities and illiteracy, which often prevail within the prison population, and to language barriers. Graphically well-designed leaflets and their translation into relevant languages will give extra support.

During the medical examination on admission, the doctor or nurse should introduce her/himself to the new prisoner, including her/his name and position, and should try to create an atmosphere of respect, confidence, privacy and dignity. The medical examination on admission, like any first medical examination in the community, should consist of a thorough medical history and physical examination. In order to be able to take immediate action following medical examinations on admission in prison, particular attention should be paid to the following requirements:

- signs of severe mental disorders,
- suicidal risk factors,
- history and signs of alcohol or drug dependency and withdrawal symptoms,
- records and/or signs of violence and ill-treatment,
- contagious diseases,
- mental or physical disabilities leading to a state of particular vulnerability in prison.

Patients suffering from acute psychosis or major depression need immediate treatment in a psychiatric facility. Likewise, prisoners at risk of suicide need immediate medical support and should be kept under special observation.[20] Neglecting to identify such prisoner patients and/or to take appropriate measures have been criticised in CPT country visit reports.[21] In such cases the European Court of Human Rights found violations of Article 2 (right to life)

20. CPT Standards 2002 (rev. 2011); CM: *The ethical and organisational aspects of health care in prison*. Recommendation R (1998) 7.
21. CPT/Inf (2006)3; (2006)24; (2012)11.

and/or Article 3 (prohibition of torture and inhuman or degrading treatment or punishment) of the ECHR.[22]

Patients who are dependent on psychoactive drugs are at risk of developing a potentially life-threatening withdrawal syndrome during their first days after imprisonment. Therefore, appropriate medical care is needed. The CPT has identified shortcomings in this regard in several country visits[23] and there is at least one case of withdrawal syndrome with a fatal outcome, in the case law of the Court in Strasbourg, that was seen as a violation of Article 3 of the ECHR (prohibition of inhuman and degrading treatment or punishment).[24]

According to the legislation in many countries, as well as the CPT standards,[25] the EPR paragraph 42.3c,[26] the Declarations of the World Medical Association (WMA)[27] and the Istanbul Protocol,[28] a prison physician has the obligation to document signs of violence and particularly any signs of ill-treatment that she/he becomes aware of, and report these to the authorities with the patient's consent. The documentation must be prepared without delay, because physical signs of violence disappear with time, and it must be properly presented before a court.[29] Such signs should be immediately reported to the relevant authorities in order to prevent the continuation of violence and ill-treatment. Also, the physical examination on admission should serve to screen for signs of violence or ill-treatment. Repeated omissions to appropriately do this have been criticised during CPT country visits.[30] Allegations of ill-treatment should be

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22. *Keenan v. UK* 27229/95; *Güveç v. Turkey* 70337/01; *Riviere v. France* 33834/03; *Renolde v. France* 5608/05; *De Donder and De Clippel v. Belgium* 8595/06; *Dybeku v. Albania* 41153/06; *Ketreb v. France* 38447/09; *Mouisel v. France* 67263/01; *Tarariyeva v. Russia* 4353/03.
23. CPT/Inf (2004)20; (2006)14; (2007)42; (2012)32.
24. *McGlinchey and others v. UK* 50390/99.
25. CPT Standards 2002 (rev. 2011).
26. CM: Recommendation Rec(2006)2 on the European Prison Rules.
27. World Medical Association: Declaration of Tokyo. *Guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment*. Tokyo 1975, rev. Divonne-les-Bains (2005); World Medical Association: *Declaration concerning support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman or degrading treatment*, Hamburg (1997); World Medical Association: *Resolution on the responsibility of physicians in the denunciation of acts of torture or cruel or inhuman or degrading treatment of which they are aware*, Helsinki (2003).
28. UN: *Istanbul Protocol. The manual on effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment* (New York/Geneva 2004).
29. CPT Standards 2002 (rev. 2011).
30. CPT/Inf (2009)1; (2009)13; (2009)37; (2010)1; (2010)33; (2011)24; (2012)1.

recorded by the prison physician and, together with the objective findings from the medical examination and the physician's conclusion regarding consistency, should be brought immediately to the attention of the relevant prosecutor.[31]

Screening for transmissible diseases during the medical examination on admission is essential to identify patients who need to be isolated and to prevent the spread of disease, such as the airborne transmission of tuberculosis. Isolation of prisoners because of the risk of infection should be applied in prison in exactly the same way as in the community[32] – so there is no reason at all to isolate prisoners because of infection with HIV or hepatitis B and C. However, education and information about the risks of acquiring these infections in prison – offering harm-reduction measures, invitations to undergo voluntary confidential counselling and testing, and, if appropriate, early treatment – should be part of the medical consultation on admission. In several recent country visits, the CPT criticised the lack or insufficiency of screening for transmissible diseases during entry medical examinations.[33]

Persons with mental or physical disabilities are particularly vulnerable to imprisonment. Due to their handicaps they cannot understand and/or cope with the strict and rigid conditions of a "total institution" like prison and are at risk of mental or physical abuse by uncaring staff and fellow inmates. It is the task of the health-care professionals to identify disabled prisoners on admission in order to offer them humanitarian assistance[34] and recommend appropriate measures to protect them. The European Court of Human Rights found a violation of Article 3 of the ECHR[35] in cases of non-compliance with this responsibility, considering it as degrading treatment.

Considering all the above responsibilities of health-care professionals during medical consultations on admission, it becomes clear that in order to fulfil all these tasks adequate time must be available for each consultation. Considering further the demand that the consultation should be performed on the day of admission, it is inevitable that the health-care team should be staffed adequately in accordance with the number of daily admissions to prisons,

31. CPT Standards 2002 (rev. 2011).
32. CPT/Inf (2009)38; (2011)20; (2012)17; (2012)32.
33. CPT/Inf (2011)26; (2012)1; (2012)4; (2012)11; (2012)15; (2012)17; (2012)32.
34. CPT Standards 2002 (rev. 2011).
35. *Price v. the United Kingdom* 33394/96.

particularly in pre-trial institutions. This issue has been addressed repeatedly by the CPT, also in recent country visits.[36]

Notwithstanding its importance, it must be borne in mind that, as a rule, the medical examination on admission, like any other medical intervention, needs the consent of the patient.[37] The health-care personnel are obliged to offer such an examination; however, the prisoner has the right to renounce it. In cases where the examination is refused, it must be documented in the medical file of the prisoner.

Medical examination after incidents of violence

In line with CM Recommendation R (1998) 7 and the CPT Standards, 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.[38]

Medical examinations after incidents of violence provide a fundamental safeguard against ill-treatment and impunity as well as against inter-prisoner violence. This relates not only to screening for signs of violence during medical examinations on admission, but also to medical examinations after every incident of violence during detention. Any allegation of violence or ill-treatment has to be recorded, followed by a thorough medical examination, medical documentation of the findings and the physician's conclusion, and these must be forwarded to the relevant prosecutor with the consent of the patient as grounds before the court.[39] In addition, every incident of violence should be included in the systematic statistical recording of violence, conducted by the health-care professionals, in order to help the authorities to assess the level of violence in a prison and to draw up preventive measures against violence. Negligence in following these recommendations has been criticised by the CPT during several country visits.[40]

36. CPT/Inf (2012)1; (2012)9; (2012)17; (2012)19; (2012)21; (2012)32.
37. CPT Standards 2002 (rev. 2011).
38. CPT Standards 2002 (rev. 2011); CPT/Inf (2011)33; (2011)24; (2012)17; (2012)34.
39. CPT Standards 2002 (rev. 2011).
40. *Slawomir Musial v. Poland* 28300/06, *Aerts v. Belgium* 25357/94.

Medical examination before release

According to the EPR, paragraph 33.6, a medical examination is part of the preparation of a prisoner for release. It should be offered as close as possible to the time of release,[41] but also in good time in order to arrange it properly. The moment when the prisoner receives the confidential medical report, which serves as medical information for the physician who will care for him/her after release, can be used as an opportunity to provide him/her with medical advice regarding his/her future health care. It is particularly important to inform drug-addicted prisoners about the high risk of fatal overdosing if they resume drug use after release.[42] Seamless medical aftercare is especially important for patients undergoing anti-mycobacterial and antiretroviral treatment because interruptions lead to the development of drug-resistant tuberculosis and drug-resistant viral strains among patients being treated by psychiatric maintenance medication or opiate-substitution maintenance. Continuation of the latter has been shown to reduce considerably the excessive death rate of drug users on the first day after release from prison.[43] Continuity of medical care during the transition from prison to the community, combined with psychosocial care, recently called "aftercare" and "through-care",[44] needs to be planned much earlier before release but the medical examination before release plays an important role in this process.

1.5 Medical documentation and record keeping

It might be argued that, given the shortage of health-care professionals and their work overload, their scarce time should be spent on immediate patient care rather than on documentation or paperwork. However, thorough documentation and record keeping is essential for qualified patient care and its continuity, not only in the interest of the patient but also in the interest of the health-care professionals and the prison administration. Allegations of defective medical care can be brought to the European Court of Human Rights if no proper medical documentation proves the contrary.[45]

41. CM: Recommendation Rec(2006)2 on the European Prison Rules.
42. WHO Europe: *Prevention of acute drug-related mortality in prison populations during the immediate post-release period* (2010).
43. CPT Standards 2002 (rev. 2011).
44. Throughcare Working in Partnership: *Throughcare services for prisoners with problematic drug use – a toolkit*, ed. M. MacDonald et al., European Commission (2012).
45. *Malenko v. Ukraine* 18660/03.

A medical file should be compiled for each patient, containing diagnostic information and all records of the patient's history, including any special examinations he/she has undergone. Daily registers should be kept by health-care teams, mentioning any particular incidents related to the patient. Such registers are useful because they provide an overall view of the health-care situation in the prison, highlighting specific problems which may arise.

The prisoner should be allowed to consult his medical file, unless this is contra-indicated for therapeutic reasons, and should be able to request that the information therein be communicated to his/her family or lawyer. In cases of prisoner transfer, the file should be sent to the doctors of the receiving establishment.[46]

Individual medical file documentation

In line with the law on health care of most countries and the principle of equivalence of care, prison health-care professionals are obliged to establish and keep a medical record file for each individual inmate.

The file should contain a full medical history, the results of the medical examination on admission, all available medical records related to the patient, including all consultations at the patient's request, with the doctor's findings, advice and treatment given. All written entries should be signed. Incomplete or even missing medical records have been identified and criticised by the CPT in several prison visits.[47] Standardised medical files should be used in all prisons of a country in order to facilitate the transfer of medical information among prison physicians when prisoners are transferred to other prison facilities. Of particular importance is the careful and detailed documentation of:

- examination on admission,
- information on any diagnoses implying serious consequences of prognosis, treatment or transmission of diseases,
- medical emergencies,
- information on examinations or treatments with possible unwanted side-effects,

46. CPT/Inf (2009)38.
47. CPT/Inf (2004)36; (2006)24; (2007)47; (2009)25; (2009)38; (2012)19 29) CPT/Inf (2004)21; (2004)36; (2010)29; (2010)20.

- informed consent and non-consent or refusal of a recommended examination or treatment,
- any records of signs of violence,
- any circumstances when medical confidentiality or the patient's consent has been breached.

Patients should receive explanations about diagnoses, prognoses, treatment recommendations, treatment alternatives, side-effects of treatments and any risks of non-treatment, so that they can give informed consent or non-consent. The information provided to the prisoner should be documented in the patient's file. For invasive medical procedures or treatments with definite unwanted side-effects, the written consent of the patient should be sought.

Only doctors, nurses and other health-care professionals who are bound to medical confidentiality may have access to medical files, which must be locked up and kept separate from prisoners' individual administrative files. Prison doctors or nurses must never allow the disclosure of patient-related medical data to the prison administration or any other third party without the explicit consent of the patient. Exceptions to this rule are: an order from a court (in such a case the doctor should hand over the information directly to the judge) and those rare cases when the doctor must decide to breach confidentiality in order to protect a strong legal right, such as saving the health or life of another person. In both cases the doctor must inform the prisoner patient accordingly. In its country visits the CPT has constantly emphasised the need to improve the confidentiality of prisoners' medical records.[48] Several states are now installing an electronic medical record system, but this needs to have safeguards in place so that only medical staff have access to medical data on individual patients.

A request from a prisoner patient to have access to his/her medical file should be accepted by the doctor. In cases of transfer, a sealed copy of the medical record should accompany the inmate and be handed over to the health-care team of the receiving institution. Upon release, the prisoner patient should be given a medical report. The medical information in the report will be used for future treatment by the physician in the community and can also include details from the records if required. Following a prisoner's discharge, the

48. CPT/Inf (2004)36; (2006)24; (2007)47; (2009)25; (2009)38; (2012)19 29) CPT/Inf (2004)21; (2004)36; (2010)29; (2010)20.

medical records must be retained by the prison service for as long as specified in the relevant national law.

Prison doctors have the duty to examine and document all signs of physical, psychological and sexual violence. During the medical examination on admission a prisoner may report police violence. It is therefore important to present any such evidence to the authorities. If the prisoner is reluctant to give consent for this, the doctor must seek ways of ensuring that the victim's identity is not revealed to the offender. The Istanbul Protocol[49] provides guidance on documentation that is valid both professionally and legally, and on non-traumatic methods of examination in cases of violence and ill-treatment.

Access to medical files and other medical information

Prisoners should be provided with all relevant information – if necessary in the form of a medical report – on their condition, their course of treatment and the medication prescribed for them. Preferably, they should have the right to consult the contents of their medical files, unless this is not advisable for therapeutic reasons. They should also be allowed to request the information to be communicated to their families and lawyers or to an outside doctor.

Statistical (non-patient-related) medical records

In line with national law and in co-operation with the community health authorities, prison doctors should keep statistical records of all aspects of health-care services performed in the prison, in particular the number of consultations and prevalence of pathologies, measured by the number of diagnoses according to the International Classification for Diseases (ICD) code, including specific records of notifiable diseases, such as tuberculosis – using the standardised case definitions and treatment categories of the World Health Organization (WHO) – dysentery, hepatitis and HIV. Such statistics are processed in a much easier way through electronic medical record systems, providing support for budgeting and for the implementation and evaluation of health-promotion and prevention programmes.

As mentioned above, prison doctors should keep statistics of all injuries and causes of injury (inter-prisoner violence and ill-treatment) and should regularly report the data to the prison authorities. Systematic statistics of violence facilitate assessment of the situation and evaluation of preventive

49. CPT Standards 2002 (rev. 2011).

measures, and may even have a preventive effect. During its prison visits[50] the CPT has constantly recommended the systematic recording of all cases of violence.

1.6 Other ethical issues

Involving prison doctors in security-related issues and disciplinary measures

Medical practitioners in prison should act as personal doctors of prisoners and should establish a positive doctor–patient relationship with them. The practice of prison doctors certifying whether a prisoner is fit to undergo solitary confinement as a punishment (or any other type of solitary confinement imposed against the prisoner's will) does not promote this relationship. This issue is emphasised in the EPR. Medical staff should never participate in any decision-making process resulting in any type of solitary confinement, unless the measure is applied for medical reasons.

On the other hand, health-care staff should be very attentive to the situation of all prisoners placed in solitary confinement. The health-care staff should be informed of every such placement and should visit the prisoner immediately after placement and thereafter, on a regular basis, at least once a day, and provide him/her with prompt medical assistance and treatment as required. They should report to the prison director whenever a prisoner's health is being put seriously at risk by being held in solitary confinement.

The prison doctor should not carry out any body searches or examinations requested by an authority, except in emergency situations when no other doctor can be called in. In those exceptional cases when the examination of body cavities cannot be avoided, it should be done by a doctor with appropriate medical training. However, in the interest of safeguarding the doctor–patient relationship, this person should not be the doctor who treats the prisoner with respect to health care. This point is also emphasised by the WMA in its Statement on Body Searches of Prisoners.[51]

Special security measures might be called for in specific cases, but the systematic placing of prisoners in barred areas when injections are administered is

50. CPT/Inf (2009)13; (2010)3; (2010)27; (2010)33; (2011)3; (2011)20; (2012)1; (2012)9.
51. WMA: Statement on body searches of prisoners, Budapest (1993, rev. 2005).

clearly unjustified. Such an approach could be considered as degrading for both prisoners and the health-care staff concerned.[52]

Professional independence of prison health-care staff

The health-care staff in any prison are potentially staff at risk. Their duty to care for their patients, sick prisoners, may often conflict with considerations of prison management and security. This can give rise to difficult ethical questions and choices. In order to guarantee their independence in health-care matters, it is important that such personnel are aligned as closely as possible to the mainstream of health-care provision in the community.

Whatever institutional arrangements are made for the provision of health care in prison, it is essential that prison doctors' clinical decisions are governed only by medical criteria and that the quality and effectiveness of their work are assessed by a qualified medical authority.[53]

Doctors treating both prisoners and prison staff

There are reservations about the practice of prison doctors treating both prisoners and prison staff.[54] The resources allocated for medical care for prisoners are often limited, and sharing doctors' working time could be to the detriment of the quality of that care. If exceptionally required by particular circumstances in an establishment, such a dual responsibility should be accompanied by very specific safeguards guaranteeing an even-handed approach. For example, it should be stipulated beforehand what percentage of the doctors' working time could be devoted to staff. It is also desirable that the two stocks of medication (for prisoners and staff respectively) be kept separate from each other. It might even be envisaged that the doctor has two separate places for consultation.

Prisoners acting as health-care staff

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

52. CPT/Inf (2011)29.
53. CPT/Inf (2004)36.
54. CPT/Inf (2006)11.

It is not within the competence of prison officers to dispense prescribed medication or to administer injections. Medication can be dispensed only by a nurse or a trained pharmaceutical dispenser; injections can be administered only by qualified health-care staff.[55]

Humanitarian assistance

There are certain specific categories of particularly vulnerable prisoners, and prison health-care services should pay special attention to their needs, as they are not always able to stand up for their interests in a detention setting. The following groups have been flagged by the CPT on several occasions.[56]

Imprisoned mothers with children

It is a generally accepted principle that children should not be born in prison, and as a rule this principle is respected. A mother and child should be allowed to stay together for at least a certain period of time and should be placed in conditions providing them with the support of staff specialised in post-natal care and nursing. Long-term arrangements, in particular the transfer of the child to the community, involving the separation from the mother, should be decided for each individual case in the light of the medical and social needs of the child.

Adolescents

While in custody, adolescents should preferably be allowed to stay in the same surroundings and have the right to keep their personal belongings. The risks of long-term social maladjustment should be minimised. The regime applied to them should be based on intensive activity, including socio-educational meetings, sport, education, vocational training, escorted outings and the availability of appropriate optional activities.

Prisoners vulnerable due to their medical or social condition

Among the patients of a prison health-care service there are a number of marginal individuals who have a history of family traumas, long-standing drug addiction, conflicts with authority or other social misfortunes. They may be

55. CPT/Inf (2011)19.

56. The CPT Standards 2002 (rev. 2011).

violent, suicidal or characterised by unacceptable sexual behaviour, and for most of the time they are incapable of controlling or caring for themselves. The needs of these prisoners are not truly medical, but the prison doctor can promote the development of socio-therapeutic programmes for them in prison units which are similar to those in the community and are carefully supervised. Such units can reduce these prisoners' humiliation, contempt and hatred, give them a sense of responsibility and prepare them for reintegration. Another direct advantage of programmes of this type is that they involve the active participation and commitment of the prison staff.

There are also prisoners who are unsuited to continued detention because of a serious disease which cannot be properly treated in prison conditions, a short-term fatal prognosis, a severe disability or advanced age. In such cases, it lies with the prison doctor to draw up a report for the responsible authority with a view to making suitable alternative arrangements.

Chapter 2

Psychiatric care and treatment plans – Therapeutic and rehabilitative psychosocial activities in prison

In comparison with the general population, there is a high incidence of psychiatric symptoms among prisoners.

Persons detained in secure psychiatric hospitals and prison inmates have much in common. Both are particularly vulnerable to developing mental health problems. Histories of abuse, deprivation, homelessness, unemployment, substance misuse and previous contact with mental health services are commonly encountered. Many prisoners have numeracy and literacy problems, and most prisoners have a below-average IQ.[1] It has been suggested that about one in seven prisoners have psychotic illnesses or major depression and about half of all male prisoners and one in five women prisoners have antisocial personality disorder.[2] Serious mental disorder is disproportionally prevalent, the highest levels of morbidity being found in the remand and women prisoner populations. Mental disorder (including

1. Singleton N., Meltzer H. and Gatward R: *Psychiatric morbidity among prisoners in England and Wales*. London: Office for National Statistics (1998); Her Majesty's Inspectorate of Prisons: *Unjust deserts: a thematic review by HM Chief Inspector of Prisons of the treatment and conditions for unsentenced prisoners in England and Wales*. London: Home Office (2000).
2. Fazel S. and Danesh J: "Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys". *Lancet*, 359 (2002), 545-50.

substance-misuse diagnoses) has been found in 37% of sentenced male prisoners, 63% of men on remand, 57% of sentenced women and 76% of women on remand. Multiple diagnoses are common, especially among remand prisoners: approximately a quarter of men and a third of women on remand received two or more diagnoses.[3]

It is clear that the burden of serious, yet treatable mental disorders in prison is substantial. Given the limited resources of the prison system, it is doubtful whether all those in need receive the appropriate care as envisaged by the ECHR.

2.1 Mental health services in prisons

The high incidence of mental disorders in a prison setting increases the responsibility of the prison health-care system. To start with, there should be a doctor qualified in psychiatry affiliated to the health-care service of each prison, and some of the nurses employed there should have training in this field. The number of medical and nursing staff and the layout of prisons should be such as to enable regular pharmacological, psychotherapeutic and occupational therapy programmes to be carried out.[4]

Measures in relation to mental health disorders in a prison setting

Not treating psychiatric illnesses in a prison setting may easily constitute inhuman and degrading treatment,[5] so ad hoc measures are needed. Those responsible should consider the following measures for prisoners with psychiatric disorders:

- motivating and training medical staff and psychologists working in prison to diagnose such cases and to participate actively in their management,
- providing specialist care in prison for such cases by assigning a psychiatrist to arrange regular consultations,
- ensuring the availability of adequate supplies of psychotropic drugs,
- ensuring that, when necessary, longer-term hospital care with an active psychosocial component is possible,

3. Gunn J., Maden A. and Swinton M: *Mentally disordered prisoners*. London: Home Office (1991); Maden A., Taylor C. J. A., Brooke D. et al: *Mental disorder in remand prisoners*. London: Home Office (1995).
4. *Slawomir Musial v. Poland* 28300/06, *Aerts v. Belgium* 25357/94.
5. CPT/Inf (2005)18; *Slawomir Musial v. Poland* 28300/06, *Aerts v. Belgium* 25357/94.

- ensuring that the transfer of a mentally ill prisoner to a psychiatric facility is treated as a matter of the highest priority.

Mentally ill prisoners treated in civil mental hospitals

A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. This could be a civil mental hospital or a specially equipped psychiatric facility within the prison system.

From an ethical standpoint, it is appropriate for mentally ill prisoners to be hospitalised outside the prison system at institutions for which the public health service is responsible. On the other hand, it can be argued that the provision of psychiatric facilities within the prison system enables care to be administered in optimal security conditions, and the activities of medical and social services can be intensified in that system.

Whichever course is chosen, the accommodation capacity of the psychiatric facility in question should be adequate, because quite often there is a prolonged waiting period before a necessary transfer is effected. The transfer of the person concerned to a psychiatric facility should be treated as a matter of highest priority.

Prisoners who are regarded as dangerous as a result of a serious mental illness should not be placed in high-security units instead of a psychiatric facility. These prisoners should have access, in a hospital environment, to treatment and appropriate therapeutic activities, administered by a sufficient number of qualified staff to provide them with the required assistance.[6]

2.2 Psychiatric units in prison

Specialised psychiatric units in prison as part of the prison health-care service can serve various purposes. The most common function is the treatment of prisoners with mental health problems who are placed there either temporarily for treatment or while waiting for transfer to a community treatment facility. On rare occasions, psychiatric units inside the prison system can also be used for holding and treating persons who have been declared criminally irresponsible, mainly in the absence of a secure facility outside the prison

6. CPT/Inf (2008)33.

system. Finally, psychiatric units can be used for the placement of persons on remand in custody for the purpose of assessing their mental state.

It is not uncommon to find that, in the absence of a specialised psychiatric unit in the prison system, prisons have established secure areas or levels for more vulnerable prisoners, including the ones with mental disorders.

General principles of care in a prison psychiatric unit

The care and custody of persons subject to placement in a penitentiary mental health-care facility as a security measure should be based on treatment and rehabilitation, while taking account of the necessary security considerations. This approach should be reflected in the living conditions and other facilities offered to this particular patient population, as well as in their treatment and activities. Such establishments should be staffed by suitably trained health-care personnel who are able to develop positive relations with the patients by entering into direct contact with them.[7] Staff resources should be adequate in terms of numbers, categories (psychiatrists, general practitioners, nurses, psychologists, occupational therapists, social workers, etc.), experience and training. Deficiencies in staff resources can lead to high-risk situations for patients, notwithstanding the good intentions and genuine efforts of the staff.

The CPT has on many occasions commented on the living conditions of people placed in psychiatric institutions.[8] This applies, *inter alia*, also to psychiatric units within the prison system. A psychiatric unit should offer material conditions which are conducive to the treatment and welfare of the patients and, in psychiatric terms, a positive therapeutic environment. Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hygiene requirements. Provision of accommodation based on small groups is a crucial factor in preserving patients' dignity, and is also a key element in any policy for the psychological and social rehabilitation of patients. Such accommodation also facilitates the allocation of patients to relevant categories for therapeutic purposes. Sanitary facilities should allow patients some privacy. Further, the needs of elderly or handicapped patients in this respect should be given due consideration; for example, lavatories of a design which do not allow the user to sit are not suitable for such patients. Similarly, basic hospital equipment

7. CPT/Inf (2007)28.
8. The CPT Standards 2002 (rev. 2011).

enabling staff to provide adequate care (including personal hygiene) to bedridden patients must be made available; the absence of such equipment can lead to wretched conditions. The practice observed in some psychiatric establishments of dressing patients in pyjamas all the time is not conducive to strengthening personal identity and self-esteem; individualisation of clothing should form part of the therapeutic process.

Psychiatric patients, including forensic patients under examination, should – health permitting – be offered at least one hour a day of outdoor exercise in a reasonably spacious and secure setting, which should also offer shelter from inclement weather.[9]

2.3 Treatment plan

Psychiatric treatment should be based on an individualised approach, which implies drawing up a treatment plan for each patient, indicating the goals of treatment, the therapeutic means used and the staff member responsible. The treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication. Patients should be involved in the drafting of their individual treatment plans and should be informed of their progress.[10]

It is important that different categories of staff working with psychiatric patients meet regularly to facilitate teamwork and discuss necessary changes in the treatment plan. This allows day-to-day problems to be identified and discussed, and guidance offered.

Psychiatric treatment

The psychiatric treatment should involve a wide range of therapeutic, rehabilitative and recreational activities, such as access to appropriate medication and medical care. Procedures must be in place to ensure that medication prescribed is properly provided and to guarantee a regular supply of appropriate medicines. Developing a range of therapeutic options, and involving long-term patients in rehabilitative psychosocial activities in order to prepare them for independent life or return to their families, may be recommended. Occupational therapy should be an integral part of the rehabilitation programme, providing for motivation, development

9. CPT/Inf (2004)40, CPT/Inf (2012)4.
10. CPT/Inf (2007)15, CPT/Inf (2009)28, CPT/Inf (2009)38.

of learning and relationship skills, acquisition of specific competences and improvement of self-image. It is also desirable to offer the patients education and suitable work.

Special attention should be paid to ensuring continuity of treatment, which consists of both pharmacotherapy and a wide range of rehabilitative and therapeutic activities. Such treatment is not designed to be turned on or off at a moment's notice; moving mentally ill persons from one environment to another with a new set of rules and ending the treatment brusquely could easily prejudice their well-being.[11]

Forensic treatment

The forensic treatment of criminally irresponsible detainees should involve a wide range of therapeutic, rehabilitative and recreational activities – including appropriate medication and medical care. The treatment should be aimed at both controlling the symptoms of the illness and reducing the risk of re-offending. It should also be emphasised that the provision of therapeutic activities to persons undergoing forensic psychiatric assessment will not interfere with the assessment process; on the contrary, it can facilitate the gathering of valuable information for that purpose.[12]

Psychopharmacotherapy

The use of medication in the treatment of mental disorders is common in both inpatient and outpatient psychiatry. Most psychotropic medications have been developed for the treatment of depression, anxiety disorders or psychotic disorders such as schizophrenia. However, some medications developed for other purposes have been found to be helpful in psychiatric treatment. Examples are the use of anti-seizure medication to treat bipolar disorders or the use of antipsychotics to treat impulse-control problems. Psychopharmacotherapy may be used alone or in conjunction with psychotherapy to treat mental disorders.[13]

11. CPT/Inf (2006)26.
12. CPT/Inf (2009)24.
13. Sadock B. J., Sadock V. and Sussman N: *Kaplan and Sadock's Pocket Handbook of Psychiatric Drug Treatment*, 4th edn, Philadelphia (2005).

Main groups of psychotropic medications

Antipsychotic drugs (neuroleptics) help to manage psychotic symptoms such as agitation, hallucinations (hearing or seeing things that are not there), delusions (false beliefs) and disorganised thinking. Antidepressants treat symptoms of depression and anxiety. Anxiolytic drugs (tranquillisers) decrease levels of anxiety and agitation.

In addition, certain psychostimulants are useful in treating attention-deficit disorder (ADHD) and there are drugs used to stabilise mood fluctuations (thymostabilisers).

Common problems in psychopharmacotherapy

Psychopharmacologic medication often forms a necessary part of the treatment given to patients with mental disorders. Procedures must be in place to ensure that any medication prescribed is properly provided, that patients take it and that a regular supply of appropriate medicine is guaranteed. There should also be vigilance for any indications of the misuse of medication.

Like any other treatment, psychopharmacologic treatment of mental disorders has its pros and cons. The most common problems are the following:

- lack of efficacy, often leading to the use of dosages exceeding therapeutic recommendations,
- side-effects of medication, some of which are not difficult to detect (parkinsonism, dystonias) – some side-effects can be discovered by tests (agaranulocytosis, hyperprolactinaemia), questioning (sexual dysfunction) or careful observation of secondary symptoms (hirsutism, metabolic syndrome),
- the need to use combinations of medication, when interactions between different drugs are important: there can be both pharmacokinetic interactions (changes in absorption, binding with proteins, metabolism or excretion) and pharmacodynamic interactions.

2.4 Consent to treatment in psychiatry

Psychiatric patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of persons to a psychiatric unit on an involuntary basis – be it in the context of civil or criminal proceedings – should not preclude staff from seeking their informed consent to treatment.

Every competent patient, whether voluntary or involuntary, should be fully informed about the treatment which is going to be prescribed and should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should relate only to clearly and strictly defined exceptional circumstances.[14]

Consent to treatment can only be qualified as free and informed if it is based on full and accurate information about the patient's condition and the treatment which is proposed. All patients should be provided systematically with information about their condition and the treatment prescribed for them.

The use of PRN (*pro re nata*, "as needed") medication should be exceptional; the doctor should be immediately notified whenever PRN medication is administered so that he/she verifies the conditions in which it was administered.[15]

Use of restraints in psychiatric units

Guidance for the use of restraints in psychiatric units can be found in the substantive section of the 16th General Report of the CPT.[16] A mentally disturbed (and possibly violent) patient should be treated through close supervision and nursing support, combined, if considered appropriate, with medication. Every psychiatric unit should have a comprehensive policy on restraint. The involvement and support of both staff and management in developing the policy is essential. Such a policy should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated. The policy should also contain sections on other important issues such as staff training, complaints policy, internal and external reporting mechanisms and debriefing.

There are various methods of controlling agitated or violent patients and they can be used separately or in combination:

- shadowing, which means a staff member is constantly at the side of a patient and intervenes in his/her activities when necessary,
- manual control,

14. CPT/Inf (2008)29, CPT/Inf (2012)11, CPT/Inf (2007)40.
15. CPT/Inf (2012)34.
16. CPT/Inf (2006)35.

- mechanical restraints such as straps, straitjackets or enclosed beds,
- chemical restraint (medicating a patient against his/her will for the purpose of controlling behaviour),
- seclusion (involuntary placement of a patient alone in a locked room).

The method chosen for a particular patient should be the most proportionate among those available in the situation. Patients should only be restrained as a measure of last resort in order to prevent imminent injury or to reduce acute agitation and/or violence. The application of means of restraint in the correct manner and appropriate environment requires that a staff member provides direct, personal and continuous supervision. Every single case of resort to means of restraint should be authorised by a doctor or brought without delay to a doctor's attention in order to seek approval for the measure.

When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately. There can be no justification for the use of restraints for lengthy periods of time (days).

Once the means of restraint have been removed, it is essential that a debriefing about the patient takes place. This provides an opportunity to explain the rationale behind the measure, thus reducing the psychological trauma related to that situation and restoring the doctor–patient relationship. The circumstances of the use of restraint should not aggravate the mental and physical health of the restrained patient.

The place where a patient is restrained should be specially designed for that specific purpose. It should be safe and have appropriate light and adequate heating, thereby promoting a calming environment. The restrained patient should be adequately clothed and not exposed to other patients. The means used to restrain the patient should be applied with skill and care in order not to endanger the health of the patient or cause pain. Vital functions, such as respiration, the ability to communicate, eat and drink must not be hampered. If a patient has a tendency to bite, suck or spit, potential damage should be averted in a manner other than by covering the mouth.

A specific register should be established to record all instances of recourse to means of restraint. This register should be in addition to the records in the patient's personal medical file. The entries in the register should include the time at which the measure began and ended, the circumstances of

the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.

Reducing recourse to the use of restraint to a viable minimum requires a change of culture in the unit. The role of management is crucial in this regard. Unless the management encourages staff and offers them alternatives, an established practice of frequent recourse to means of restraint is likely to prevail.

Psychiatric care after discharge

For persons who had been undergoing psychiatric treatment, steps should be taken to assure their continued care. Although no longer requiring placement in a psychiatric unit, a patient may nevertheless still need treatment or may benefit from a protected environment.[17] It is necessary to provide for continuity of treatment when prisoners are transferred back to their custodial setting.

2.5 Suicide prevention

Given the high incidence of mental disorders in prisons, the prison medical services should be concerned about mental hygiene issues, including prevention of the harmful psychological effects of certain aspects of detention. It is well known that effective prevention can reduce the risk of mental disorders.[18]

Organisational approach to suicide prevention

Suicide prevention requires intervention also from outside the health sector.[19] In its 3rd General Report[20] the CPT made several recommendations in this respect. Prison management, including the head of the prison health service, should ensure that there is an adequate awareness of suicide prevention throughout the establishment and that appropriate procedures are in place.

17. CPT/Inf (98)12.
18. *Prevention of mental disorders: effective interventions and policy options*. A report of the World Health Organization. Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht, WHO (2004).
19. *Public health action for the prevention of suicide*, WHO (2012).
20. CPT/Inf (93)12.

Active suicide-prevention efforts are needed through the provision of supportive monitoring and the development of a relationship of trust between inmates and staff. Measures should be taken to ensure that prevention efforts are adequately co-ordinated, in particular by regular and frequent meetings of the multidisciplinary team and by adequate input from specialist staff such as psychiatrists and educators.

In the case of high suicide rates, alternative suicide-prevention measures should be introduced, such as increased and varied activities, opportunities for association, contacts with the outside world and effective, multidisciplinary addiction treatment.

Identifying suicide risk

In addition to medical screening on admission, the reception and first-night procedures as a whole have an important role to play. Performed properly, they can identify at least certain of those at risk of self-harm and relieve some of the anxiety experienced by all newly-arrived prisoners. The periods immediately before and after trial and, in some cases, the pre-release period are associated with an increased risk of suicide.[21]

Training staff to recognise suicide risk

The prevention of suicide, including the identification of those at risk, should not rest with the health-care service alone. All prison staff in contact with inmates – and, as a priority, staff who work in the reception and admission units – should be trained in recognising indications of suicidal risk.[22]

Assessing the risk of suicide

A standard screening algorithm should be introduced to assess the risk of suicide (and self-harm) in prison. Such a tool should, in particular, ensure that drug and/or alcohol dependency are adequately taken into account in the screening process as factors potentially heightening the risk of suicide.

Steps should be taken to ensure that information on an inmate at risk of suicide or self-harm is transmitted in full and promptly to all those who

21. CPT/Inf (2012)1.
22. The CPT Standards 2002 (rev. 2011).

have a role in caring for the prisoner, including when he/she is transferred to another establishment.

Dealing with persons at suicide risk

A person identified as being at risk of suicide should, for as long as necessary, be kept under a special observation scheme. Further, such persons should not have easy access to means for committing suicide (cell window bars, broken glass, belts or ties). All persons identified as presenting a suicide risk should benefit from counselling, support and appropriate association.

A prisoner showing severe signs of suicidal or (auto)-aggressive behaviour should be immediately transferred to an acute mental health unit. Should the person remain in prison, the treatment and care should be overseen by medical staff and be subject to regular medical visits and follow-up.[23]

2.6 Other mental health problems in prison

Prisoners with self-harming behaviour

Acts of self-harm frequently reflect problems and conditions of a psychological or psychiatric nature and should be approached from a therapeutic rather than a punitive standpoint. Isolation of the prisoners concerned (even if it is not considered as a disciplinary measure) is likely to exacerbate their psychological or psychiatric problems. All cases of self-harm should be assessed medically, immediately after the incident, in order to evaluate the extent of lesions and to assess the psychological state of the prisoner.[24]

Medical management of hunger strikers in prison

The management of hunger strikers in prison is a controversial issue. Both CM Recommendation No. R (1998) 7 on the ethical and organisational aspects of health care in prison and the WMA Declaration on Hunger Strikers, adopted in Malta on 1991, leave to the physician the discretion to act in a situation where a hunger strike becomes life-threatening for the prisoner.[25] The tension between the duty to secure the right of a prisoner to life and the duty to

23. CPT/Inf (2011)5.
24. CPT/Inf (2009)35.
25. CM: *The ethical and organisational aspects of health care in prison*. Recommendation R (1998) 7; WMA: Declaration of Malta on Hunger Strikers (2006).

respect the autonomy of the individual needs to be addressed, in accordance with medical ethics and also with the legislation of the particular country. The European Court of Human Rights has in its ruling *X v. Germany* stated that, when a detained person maintains a hunger strike, this may inevitably lead to a conflict between an individual's right to physical integrity and the contracting party's obligation under Article 2 of the Convention – a conflict which is not resolved by the convention itself.[26] However, the Court has considered that a situation where repeated force-feeding is not prompted by valid medical reasons but rather aims to force the applicant to stop the protest, and is performed in a manner which unnecessarily exposes the prisoner to great physical pain and humiliation, amounts to torture.[27]

The CPT has reflected upon this issue in one of its visit reports.[28] State authorities have a duty of care with respect to persons in their custody. This duty of care includes the protection of a detained person's life, including the prevention of suicide and of any other act by the person concerned likely to cause death or irreversible physical damage. Therefore, a decision to feed against his will a prisoner on hunger strike can in principle be justified in order to prevent the prisoner from suffering irreversible physical damage or death. On the other hand, the majority of national legislations in Europe, as well as relevant international medical ethical codes, today consider that a competent adult may choose to refuse medical treatment even if it could save his life. Consequently, the authorities involved in the management of a hunger strike by a prisoner may often be faced with two potentially conflicting values: their duty of care to safeguard a life and the prisoner's right to physical integrity (including the right not to have a treatment imposed on him).

CM Recommendation No. R (1998) 7 defines the basic principles of addressing the hunger strike issue.

- Hunger strikers should be given an objective explanation of the harmful effects of their action upon their physical well-being, so that they understand the dangers of prolonged hunger striking.
- Clinical assessment of a hunger striker should be carried out only with the express permission of the person, unless he or she suffers from serious mental disorders which require the transfer to a psychiatric service.

26. Case of *X v. Germany* (1984) 7 EHRR 152.
27. *Ciorap v. Moldova* 12066/02, *Nevmerzhitsky v. Ukraine* 54825/00.
28. CPT/Inf (2007)10.

- If, in the opinion of the doctor, the hunger striker's condition is becoming significantly worse, it is essential that the doctor reports this fact to the appropriate authority and takes action in accordance with national legislation and professional standards.

The WMA Declaration on Hunger Strikers goes further in detail when addressing this issue. Stating that genuine and prolonged fasting risks death or permanent damage for hunger strikers, it also reveals the fact that hunger strikers usually do not wish to die but some may be prepared to do so to achieve their aims. WMA gives clear guidance to the physician how to act in case of a hunger strike.

- Physicians must assess individuals' mental capacity. This involves verifying that an individual intending to fast does not have a mental impairment that would seriously undermine the person's ability to make health-care decisions. Individuals with seriously impaired mental capacity cannot be considered to be hunger strikers. They need to be given treatment for their mental health problems rather than allowed to fast in a manner that risks their health.
- As early as possible, physicians should acquire a detailed and accurate medical history of the person who is intending to fast. The medical implications of any existing conditions should be explained to the individual. Physicians should 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 minimised or delayed by, for example, increasing fluid 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. Consistent with best practices for informed consent in health care, the physician should ensure that the patient understands the information conveyed by asking the patient to repeat back what they understand.
- A thorough examination of the hunger striker should be made at the start of the fast. Management of future symptoms, including those unconnected to the fast, should be discussed with the hunger strikers. Also, the person's values and wishes regarding medical treatment in the event of a prolonged fast should be noted.
- Sometimes hunger strikers accept an intravenous saline solution transfusion or other forms of medical treatment. A refusal to accept

certain interventions must not prejudice any other aspect of the medical care, such as the treatment of infections or of pain.

- Physicians should talk to hunger strikers in privacy and out of earshot of all other people, including other detainees. Clear communication is essential and, where necessary, interpreters unconnected to the detaining authorities should be available and they too must respect confidentiality.

- Physicians need to satisfy themselves that food or treatment refusal is the individual's voluntary choice. Hunger strikers should be protected from coercion. Physicians can often help to achieve this and should be aware that coercion may come from the peer group, the authorities or others, such as family members. Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon suspension of the hunger strike.

- If a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another physician who is willing to abide by the hunger striker's refusal.

- Continuing communication between the physician and hunger strikers is crucial. Physicians should ascertain on 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. These findings must be appropriately recorded.

- When a physician takes over the case, the hunger striker may have already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life. Consideration needs to be given to any advance instructions made by the hunger striker. Advance refusals of treatment demand are respected if it reflects the voluntary wish of the individual when competent. In custodial settings, the possibility of advance instructions having been made under pressure needs to be considered. Where physicians have serious doubts about the individual's intention, any instructions must be treated with great caution. If well informed and voluntarily made, however, advance instructions can only generally be overridden if they become invalid because of the situation in which the decision was made has changed radically since the individual lost competence.

- If no discussion with the individual is possible and no advance instructions exist, physicians have to act in accordance in what they judge to be 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. In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties.
- Physicians may consider it justifiable to go against advance instructions refusing treatment because, for example, the refusal is thought to have been made under duress. If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected. It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will.
- Artificial feeding can be ethically appropriate if competent hunger strikers agree to it. It can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it.
- Forcible 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.

As we can see, the WMA considers force-feeding ethically unacceptable. There is a conflict of values between the duty of care to safeguard life and the right to physical integrity. Physicians should, however prevent any act that could amount to torture or inhuman and degrading treatment.

If a decision is nevertheless taken to force-feed a prisoner on hunger strike, such a decision should be based upon medical necessity and should be carried out under suitable conditions that reflect the medical nature of the measure. The decision-making process should follow an established procedure, which contains sufficient safeguards, including independent medical decision-making. Psychiatric assessment of the mental health of an inmate on hunger strike can be helpful in determining those cases where the reasons behind food refusal are of a psychiatric nature. Further, psychiatric examinations throughout the course of a hunger strike would assist the treating medical team in detecting any mental deterioration that could affect hunger strikers' capacity to make well-informed choices about their life and health. Legal recourse should be available and all aspects of implementation of the decision should be

adequately monitored. The methods used to execute force-feeding should not be unnecessarily painful and should be applied with skill and minimum force. Force-feeding should infringe the physical integrity of the hunger striker as little as possible.

Treatment of sexual offenders in prison

The treatment of patients with paraphilias, irrespective of which method of treatment is used, has always been undertaken through a minefield of clinical and ethical dilemmas. The major ethical issues regarding sex offenders, including paraphilias, may reflect the need for public safety and even a professional orientation towards punishment rather than treatment, even when the treatment is appropriate and effective.[29]

The CPT has addressed the issue in its several reports.[30] Its recommendations could be summarised as follows.

- Measures taken to counter re-offending should never be based on efficacy alone. Narrow focus on lowering re-offending rates may pave the way to serious human rights abuse. Different treatment options are available, based on psychotherapy (including group therapy), pharmacotherapy (including the use of anti-androgens) or a combination of the two;
- Before starting any medical treatment, the free and informed written consent of the person concerned should be obtained before the start of pharmacotherapy (including anti-androgen treatment), allowing for the consent to be withdrawn at any time. The prisoner in question should be given a detailed explanation (including in writing) of the purpose and possible adverse effects of the treatment, as well as the consequences of refusal to undergo such treatment.

Anti-androgen treatment should always be based on a thorough individual psychiatric and medical assessment and such treatment should be on purely voluntary basis. A comprehensive and detailed procedure should be developed, including additional safeguards: inclusion and exclusion criteria for

29. Bowden P., "Treatment: use, abuse and consent". *Criminal Behaviour and Mental Health* 1 (1991), 130-41; Berlin F., "Sex offender treatment and legislation". *Journal of the American Academy of Psychiatry and the Law* 31 (2003), 510-13; Ward T., Gannon T. A. and Birgden A., "Human rights and the treatment of sex offenders". *Sex Abuse* 19/3 (2007), 195-204; Elger B. S., "Research involving prisoners: consensus and controversies in international and European regulations". *Bioethics* 22 (2008), 224-38.

30. CPT/Inf (2009)8; (2011)20.

such treatment; medical examinations before, during and after treatment; access to outside consultation, including an independent second opinion; and regular evaluation of the treatment by an independent medical authority. The administration of anti-androgens should be combined with psychotherapy and other forms of counselling in order to further reduce the risk of re-offending. Further, anti-androgen treatment should not be a general condition for the release of sex offenders, but should be administered to selected individuals based on an individual assessment.

Surgical castration is an intervention that has irreversible physical effects, and direct or indirect mental health consequences. Further, there is no guarantee that the result sought (lowering of the testosterone level) will last. The legitimate goal of lowering re-offending rates must be counterbalanced by ethical considerations linked to the fundamental rights of an individual.[31] Surgical castration is no longer a generally accepted medical intervention in the treatment of sex offenders. Irreversible medical interventions should never be carried out on prisoners or other detained persons unless there is a clear medical necessity.

2.7 Dual diagnosis in prisons

At an estimate, 3-11% of prison inmates have mental health problems (such as psychotic disorder or mood disorder) co-occurring with a substance-abuse disorder.[32]

The term "dual diagnosis" covers a wide range of problems that have mental health and substance misuse in common. Dual diagnosis can have different meanings to different health-care services, but the four commonest combinations are:

- a primary mental health problem that provokes the use of substances (such as someone suffering from schizophrenia who finds that heroin reduces some of the symptoms),

31. Alexander M., Gunn J., Cook D. A. G., Taylor P. J. and Finch J., "Should a sexual offender be allowed surgical castration?" *British Medical Journal* 307 (1993), 790-93.
32. Edens J. F., Peters R. H. and Hills H. A., "Treating prison inmates with co-occurring disorders: an integrative review of existing programs". *Behavioral Sciences & the Law* 15/4 (1997), 439-57.

- substance misuse and/or withdrawal leading to psychiatric symptoms or illness (emergence of depression post-detoxification, with insomnia and low mood),
- a psychiatric problem that is worsened by substance misuse (a person with high anxiety of danger from others who uses cannabis to relax, but finds that the cannabis can increase their paranoia, leading to increased alienation),
- substance-misuse and mental health problems that do not appear to be related to one another (someone who has an ongoing anxiety problem that is neither lessened nor worsened by drug or alcohol use).

While in prison, where there is less ready access to illicit drugs, a patient's mental state may appear stable. On the other hand, a relatively low-stimulus environment such as prison can further mask existing mental health problems. Even low or moderate drug use (relatively small and infrequent consumption of drugs such as cannabis or amphetamine) that is not problematic for the great majority of substance users can have detrimental effects on persons with serious mental health problems. Different interventions are needed to manage withdrawal from alcohol and all drugs of dependence, and to manage opioid maintenance and prevent a relapse into problems of drinking or drug use after release.[33]

- Opiate-dependent patients arriving in prison custody with serious mental health problems should be stabilised – rather than detoxified – for a minimum period of two weeks. Quick detoxification should be avoided.
- Benzodiazepine withdrawal may cause the emergence of symptoms of psychosis; patients with a previous history of thought disorder may be more vulnerable to this effect. A period of stabilisation may be required before any further reduction in diazepam is considered. Anxiety and self-harm can emerge as a result of withdrawal of benzodiazepines; stabilisation followed by a slower reduction may again be indicated.
- Withdrawal from stimulants can cause a brief but sometimes profound depression. It may take from one week to several months to resolve this, as the central nervous system adapts physiologically to the changed chemical environment. During this time a prisoner may be at enhanced risk of suicide or self-harm. Additionally, stimulant use can cause a

33. *A guide for the management of dual diagnosis for prisons*. Department of Health, London (2009).

psychotic episode ("amphetamine psychosis"). Cessation of stimulant use, sleep and nourishment will usually reverse this problem. It is also important to note that stimulant use is common among those who suffer from chronic boredom or a high stimulus threshold, which is common in individuals with a personality disorder, in particular borderline or antisocial personality disorder. Thus, identification of an underlying personality disorder will be important for treatment planning.

Placing individuals with dual diagnosis in group treatment needs to be considered carefully. Many people with significant mental health difficulties have had highly traumatic childhoods and recent histories. They are also likely to have some difficulties with socialising. These issues are particularly relevant for those with a personality disorder. Thus, careful and complete assessment and psychological formulation is important for making decisions about group or individual treatments.

2.8 Prisoners with personality disorders

The term "personality disorder" is mainly used to describe problematic ways of coping with everyday life and dealing with oneself, others and the world. Personality disorder is believed to be a result of the interplay between genetic and environmental factors and disrupted early development.

Personality disorders are common in society. Epidemiological estimates suggest that 5-13% of people have problems that meet the diagnostic criteria for personality disorder. Epidemiological studies also indicate that 20-50% of people with personality disorders misuse psychoactive substances and 5-30% of persons known to substance-misuse services have been diagnosed with a personality disorder.

Among the patients of a prison health-care service there will always be a certain number of unbalanced, marginal individuals who have a history of family traumas, long-standing drug addiction, conflicts with authority or other social misfortunes. They may be violent, suicidal or characterised by unacceptable sexual behaviour, and are for most of the time incapable of controlling or caring for themselves. Prison studies show that some 50-78% of prisoners have been found to have personality disorders.[34] Prisoners with a personality disorder

34. Coid J. and Yang M., "Prevalence and correlates of personality disorder in Great Britain". *British Journal of Psychiatry* 188 (2006), 423-31; Linehan M., Schmidt H. et al., "Dialectical behavior therapy for patients with borderline personality disorder and drug dependence".

are challenging. For a relatively small number, in its most severe forms, it is linked to a serious risk of harm to themselves and to others. These offenders have highly complex psychological needs that create challenges in terms of management, treatment and maintaining a safe working environment.

Specialised units have demonstrated the ability to manage the most difficult offenders safely and constructively, and deliver high-quality therapeutic approaches; evidence is beginning to show a significant decrease in adjudications and violent incidents. Guidelines have been developed for the treatment and management of personality disorders[35] that are helpful in planning services for these categories of prisoner. The focus should be on the reduction of offending behaviours, violence, aggression and substance abuse.

Persons with psychopathy and those who meet the criteria for dangerous and severe personality disorder represent a small proportion of people with antisocial personality disorders. However, they present a very high risk of harm to others and consume a significant proportion of welfare services. Cognitive and behavioural interventions, for example, can focus on reducing offending and other antisocial behaviour. Such interventions should be adapted to this group by combining concurrent individual and group sessions and should be longer in duration and supported by continued follow-up and close monitoring.

Pharmacological interventions should not be routinely used to treat personality disorders or associated behaviours of aggression, anger and impulsivity. However, pharmacological interventions for co-morbid mental disorders, in particular depression and anxiety, could be necessary. When starting and reviewing medication for co-morbid mental disorders, particular attention should be paid to issues of adherence and the risks of misuse and overdose.

Treatment for any co-morbid disorder is of the utmost importance and should happen regardless of whether the person is receiving treatment for a personality disorder, because effective treatment of co-morbid disorders may reduce the risk associated with psychopathy or dangerous and severe personality disorder.

American Journal on Addictions 8/4 (1999), 279-92; Nace E., Davis C. and Gaspari J., "Axis II co-morbidity in substance abusers". *American Journal of Psychiatry* 148 (1991), 118-20; Singleton N., Meltzer H. et al., *Study of psychiatric morbidity among prisoners in England and Wales*. Office for National Statistics, London (1998).

35. NICE Clinical Guidelines: *Antisocial personality disorder: treatment, management and prevention*. NHS (2009); NICE Clinical Guidelines: *Borderline personality disorder: the NICE guideline on treatment and management*. British Psychological Society/Royal College of Psychiatrists (2009).

Staff working with people with antisocial personality disorders should recognise that a positive and rewarding approach is more likely to be successful than a punitive approach in engaging and retaining people in treatment. Staff should explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable. They should build a relationship of trust, work in an open, engaging, unprejudiced manner and be consistent and reliable. Staff working with such patients should receive proper training, support and supervision, preferably from outside the unit. This helps to deal with the emotional pressure and prevent staff burn-out.

Chapter 3

Preventing the spread of HIV/Aids and hepatitis B/C in prisons

3.1 Epidemiological background

In contrast to the worldwide decrease in the incidence of new HIV infections and Aids-related deaths over the last decade, there has been an increase of more than 25% in new HIV infections and Aids-related deaths during the same period in eastern Europe and Central Asia. The number of people with HIV infections in this region has tripled since 2000 and the dynamic of the epidemic is predominantly driven by transmission among people who inject drugs: at least one quarter of the estimated 3.7 million people who inject drugs in this region have HIV infection.[1] Hepatitis C virus infection rates in injecting drug users are reportedly 40-90%.[2]

The increased prison population in many countries has largely been the result of intensified law enforcement against the supply, possession or use of illicit drugs and is being accompanied by an increase in the number of prisoners who consume and inject drugs. Up to 30% of prisoners have a history of injecting drugs. This is the main reason why HIV and hepatitis C and B prevalence rates among prisoners are up to 30 times higher than among people of comparable age living in the community. Hence, prisons must be regarded as epidemiological epicentres for such parenteral transmissible infections as blood-borne and/or sexually transmissible infections, for several reasons.

- Prisons have a concentration of persons with risk behaviour for infections from intravenous drug use (IDU), sharing of injection instruments,

1. UNAIDS: Report on the global AIDS epidemic 2010 (November 2010).
2. EMCDDA (European Monitoring Centre for Drugs and Drug Addiction).

tattooing with shared instruments and unprotected promiscuous sex. The HIV epidemic in prison is predominantly driven by IDU but it would be a mistake to neglect sexual transmission in prison.

- Such risk behaviours continue, resume or start in prison, often under more risky conditions than in the community, so transmissions and even epidemics have occurred and continue to occur.[3]
- Preventive and harm-reduction measures are difficult to apply and often are not available in prison.
- Access to diagnostic measures and treatments aiming to reduce the virus load of infected persons in prison is often deficient, less available than in the community or not available at all.
- Released prisoners who acquired infections during detention may, often without knowing, transmit their infection to the community. The high degree of mobility between prison and community typical of convicted drug users, who mostly serve short, repetitive prison sentences, increases this risk to public health.

3.2 International documents

Failure to provide prisoners with access to essential prevention measures and treatment that are equivalent to those available in the community is a violation of prisoners' right to health and against international law such as the International Convention on Economic, Social and Cultural Rights and the European Social Charter.[4] A number of recommendations, rules, declarations and resolutions by the Council of Europe and other international bodies underline the obligation of prison authorities to provide preventive health care, especially against HIV and hepatitis C epidemics in prison.[5]

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3. Jürgens R., Nowak M. and Day M: "HIV and incarceration: prisons and detention". *Journal of the International AIDS Society* 14:26 (2011); WHO/UNODC/UNAIDS: *Interventions to address HIV in prisons: comprehensive review*, Evidence for Action Technical Paper (Geneva 2007); WHO/UNODC/UNAIDS: *Effectiveness of interventions to address HIV in prisons*, Evidence for Action Technical Paper (Geneva 2007); WHO Europe: Policy guidance on HIV in prisons at www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/policy-guidance-for-key-populations-most-at-risk2/hiv-in-prisons.
4. Article 12 of the International Convention on Economic, Social and Cultural Rights; Article 11 of the European Social Charter.
5. WHO Europe: Policy guidance on HIV in prisons at www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/policy-guidance-for-key-populations-most-at-risk2/hiv-in-prisons; CM: *Prison and criminological aspects of the control of transmissible diseases including AIDS and related health problems in prison*. Recommendation R (1993) 6; CM: *The ethical and organisational aspects of health care*

During recent country visits, the CPT has identified severe deficiencies in preventive measures against spread of HIV/Aids and hepatitis C.[6] Preventive measures against the spread of HIV/Aids and hepatitis B/C in prison can be summarised in four steps: improvement of attitudes and knowledge, reduction of drug supply and demand, harm reduction and medical measures.

3.3 Improvement of attitudes and knowledge

Acceptance of taboo realities

Prison authorities and politicians all over the world hesitate to acknowledge and admit the fact that there are drugs, drug use and sexual activity in prison, for fear that the public will make them responsible and accountable for the fact. However, as long as these realities are taboo, it will remain difficult, if not impossible, to implement appropriate measures against the transmission of viruses in prison. Politicians and the public need to learn that preventing the spread of HIV and hepatitis C and other infections in prison is important not only for the health of prisoners, a matter usually not of high political priority, but also for the sake of general public health. The Moldovan model of a needle/syringe-exchange programme in prison, an impressive and exceptional example of good practice in preventing the spread of these infections, became possible only when the authorities, and later the public, accepted these realities. This was a good example of effective policy necessary to introduce new strategies.[7]

Alternatives to imprisonment

Exhausting all available alternatives before incarcerating drug-dependent offenders is probably the most effective strategy in preventing the spread

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in prison. Recommendation R (1998) 7; The CPT Standards 2002 (rev. 2011); UNAIDS/UNODC/WHO: *HIV/AIDS Prevention, care, treatment and support in prison settings: a framework for an effective national response* (New York 2006); WHO Europe: *WHO guidelines on HIV infection and AIDS in prisons* (Geneva 1993); Møller L. et al: *Health in prisons: a WHO guide to the essentials in prison health* (Geneva 2007); Penal Reform International: *Dublin Declaration on HIV/AIDS in prisons in Europe and Central Asia* (Dublin 2004); World Medical Association: *Declaration of Edinburgh on prison conditions and the spread of tuberculosis and other communicable diseases* (Edinburgh 2000, rev. Montevideo 2011); UNODC: *HIV prevention and care in prisons and other closed settings: a comprehensive package of interventions*, Policy Brief (Vienna 2012).

6. CPT/Inf (2009)1; (2009)35; (2010)33; (2011)20; (2011)29; (2012)4; (2012)32.
7. Prison Needle Exchange: *Lessons from a comprehensive review of international evidence and experience*, 2nd edn (2006), Canadian HIV/AIDS Legal Network.

of parenteral transmissible infections in prison. Countries vary considerably in how they punish illicit drug use and possession of illicit drugs for personal use. Given the high risk of infection transmission, serious consideration should be given to the negative psychosocial impact of incarceration, particularly on young drug-dependent persons, the lack of appropriate treatment and rehabilitation facilities for drug dependency in prison settings, the legal framework and sentencing practices, especially the imprisonment of drug-dependent offenders. All possible alternatives to incarceration for the many petty crimes of drug users should be considered at all levels of the criminal justice system – police, pre-trial period, court, post-trial – and various alternatives to prison – diversion, alternative sanctions, release on parole – should be sought, combined with treatment offered in the community.[8]

Education and training

In line with the principles of health promotion in prison,[9] continuous education and training programmes on HIV/Aids and hepatitis B and C should include the whole prison community: prisoners, prison staff, prison administration and persons with or without risk behaviour. The programmes should include information on the aetiology and pathogenesis of relevant infectious diseases, their course, symptoms, diagnosis and treatment, and particularly the routes and means of transmission, ways they will not be transmitted, how to protect oneself and others, harm-reduction measures and what to do after possible exposure. They should also include an invitation to voluntary confidential counselling and testing. However, information about harm-reduction measures and testing is only preventive if they are also provided and accessible in prison. The training programmes must take into account the high prevalence of illiteracy, learning difficulties and language barriers in the prison population. The frequency of regular education and training events on this issue should consider the turnover rate of inmates and staff, as well as the importance of keeping knowledge and awareness of the topic alive.

It is the obligation of health-care professionals that, as well as providing information individually, face to face, during medical consultations on admission (see above, Medical consultation on admission), they ensure education and

8. UNODC: *From coercion to cohesion: treating drug dependence through health care not punishment*, Discussion paper of a scientific workshop, 28-30 October 2009 (Vienna 2010); EMCDDA: *Alternatives to imprisonment — targeting offending problem drug users in the EU* (Lisbon 2005).
9. Møller L. et al: *Health in prisons: a WHO guide to the essentials in prison health* (Geneva 2007).

training on preventive health care are also organised with the support of the prison administration. They can and should rely on the experience, facilities and tools that many NGOs have for training on HIV/Aids and hepatitis B and C, and they should also try to persuade prison administrations to seek their support in this regard.

Various methodologies of education can and should be applied: face-to-face education, group discussions, role plays, theatre sketches followed by discussion, leaflets, films and other audiovisual tools. Peer education seems to be especially effective for injecting drug users. Invitation to screening by VCCT (voluntary confidential counselling and testing) should be an integral part of education.

3.4 Reduction of drug supply and demand

The importance of intensified checks and searches to prevent drug supply in prison is beyond any doubt. Because of the high number of imprisoned drug-dependent persons, prisons are a favourite target of the illegal drug market, prison subcultures and unofficial power structures in many prisons in the world, which are dominated by the interests of this illegal market. Reality has shown that checks and searches cannot keep prisons completely free of drugs. It has been reasoned that searches alone, without being accompanied by other preventive measures, might even be counterproductive in prevention of the spread of parenteral transmissible infections: drugs packed in tiny volumes are easy to smuggle into prisons in comparison to the more voluminous injection instruments. This results in drug supply without adequate injection-equipment supply, with the consequence of repetitive and shared use of scarce injection equipment and thus virus transmission. As in the community, a well-balanced four-pillar policy – enforcement, prevention, harm reduction and treatment – can more efficiently reduce the risks of drug use in prison while preventing the spread of transmissible diseases by injecting drugs.

It should be kept in mind that, according to the principles of medical ethics and international recommendations, health-care professionals caring for prisoners should never involve themselves in checks, searches, body searches or drug tests done for security reasons, or they may lose the trust of their patients.[10] These actions are exclusively the duty of the security staff. If a physician is

10. CM: *The ethical and organisational aspects of health care in prison*. Recommendation R (1998) 7; The CPT Standards 2002 (rev. 2011); World Medical Association: *WMA Statement on Body Searches of Prisoners* (Budapest 1993, rev. 2005).

needed for intimate body checks, it should be a public health officer or a physician not involved in the care of prisoners.

Drug-free prison departments

Several countries have established drug-free zones or departments in prisons, where prisoners consent to frequent random urine tests proving them to be drug-free in return for incentives with privileges and/or better living conditions compared to regular prison departments. Inmates showing positive in drug tests are immediately sent back to a regular prison department. This combination of stimulating motivation with monitoring control has proved successful in preventing demand and supply of drugs, strengthening prisoners' autonomy, reducing conflict and improving the working conditions for staff. This is suitable only for prisoners who have a high motivation not to get in contact with drugs while serving their prison sentence.[11]

Substitution treatment programmes

Oral opioid-maintenance substitution is not only the most effective and best documented treatment for opiate dependency, and thus regarded as state-of-the-art treatment for opiate-injecting drug users, but is also as one of the most powerful preventive measures against the spread of HIV/Aids and hepatitis B and C. It reduces the demand for risky intravenous consumption of opiates, stabilises the patients so that they can undergo additional psychotherapeutic treatment and helps to retain them in psychosocial treatment.[12]

In line with the principle of equivalence of care, which applies not only to therapeutic but also to preventive health care,[13] in all countries where opiate-substitution programmes are implemented in the community, they should also be available in prison. This is essential not only for ethical reasons but also for clear clinical and preventive reasons: interruption of opiate substitution leads to an opiate-withdrawal syndrome in the vulnerable phase of imprisonment and increases the risk that intravenous drug use is resumed. As a rule, viral transmission is much more risky in the prison environment than

11. EMCDDA: Best practice portal: *Drug free zone in Hirtenberg prison* (2001) at www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=57&tab=overview.
12. WHO/UNODC/UNAIDS: "Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention", position paper (2004).
13. The CPT Standards 2002 (rev. 2011).

in the community. In addition, opiate-maintenance substitution in prison has been proved to reduce considerably the excessive death rate of drug users on the first day after release from prison.[14]

Because of all these factors, at least 26 countries in Europe have introduced opiate-maintenance substitution in prisons and in seven European countries more than 10% of all prisoners are undergoing opiate-substitution treatment.[15] Methadone is the most frequently used substitution drug but other oral opioids are also used. There is already extensive experience with elaborate guidelines on how to run opiate-substitution programmes in prison.[16] However, recent CPT country visit reports have emphasised that, in several prison systems in Europe, still much needs to be done in order to comply with this important prevention strategy.[17]

Psychotherapeutic treatment and psychosocial care may help to reduce demand for drugs among opiate-dependent intravenous drug users, especially when combined with opiate-substitution treatment, and thus may also help to prevent the spread of blood-borne virus diseases, particularly since psychotherapeutic treatment concepts currently focus more on harm reduction than on complete abstinence.

3.5 Harm reduction of risky behaviour

Evidence has shown that it is unrealistic to presume that security measures in prison can end risk behaviour related to the spread of HIV/Aids and hepatitis B and C. It has also shown that risk behaviour under prison conditions may create even greater risks than in the community, so measures for reducing such harm in prison are just as important as in the community.[18]

14. WHO Europe: *Prevention of acute drug-related mortality in prison populations during the immediate post-release period* (Geneva 2010).
15. EMCDDA: (2010)
16. WHO Europe: *WHO guidelines on HIV infection and AIDS in prisons* (Geneva 1993); Møller L. et al: *Health in prisons: a WHO guide to the essentials in prison health* (Geneva 2007); Kastelic A., Pont J. and Stöver H: *Opioid substitution treatment in custodial settings: a practical guide* (Oldenburg 2009).
17. CPT/Inf (2011)3; (2011)20; (2011)29; (2012)4; (2012)9; (2012)17; (2012)32.
18. WHO Europe: Policy HIV/AIDS in prison; Jürgens R., Nowak M. and Day M: "HIV and incarceration: prisons and detention". *Journal of the International AIDS Society* 14:26 (2011); WHO/UNODC/UNAIDS: *Interventions to address HIV in prisons: comprehensive review*, Evidence for Action Technical Paper (Geneva 2007); WHO/UNODC/UNAIDS: *Effectiveness of interventions to address HIV in prisons*, Evidence for Action Technical Paper (Geneva, 2007); CM: *The ethical and organisational aspects of health care in prison*.

Less risky use

Information and education on the risks of HIV and hepatitis B and C virus transmission by sharing contaminated injection equipment are prerequisites for harm reduction of drug use. In trying to achieve the greatest effect with the least drug dose, most opiate-addicted prisoners go for the intravenous route, behaviour that can be effectively reduced by sufficiently dosed oral opioid-substitution treatment. Hence, oral opioid substitution is a measure for reducing demand for consumption of illegal opiates and is a safer use of an opiate. In those prisons where sterile injection paraphernalia are not available (see below, Needle/syringe-exchange programmes), prisoners should at least have access to disinfectants together with information how to rinse and disinfect contaminated injection equipment in order to lessen the risk of transmission. However, it must be made very clear that disinfecting is anything but safe use and that the only way to avoid transmission is not to use contaminated instruments at all. When household bleach (5.25% sodium hypochlorite) is used as disinfectant, it must be fresh and undiluted in order to have any effect at all.[19]

Needle/syringe-exchange programmes

There is compelling evidence that needle/syringe-exchange programmes in the community are effective in reducing HIV infection among injecting drug users; they are cost-effective and have no negative unintended consequences.[20] The philosophy of needle-exchange programmes is not only to provide sterile injection equipment to injection drug users, but also to safely dispose of contaminated injection instruments, which is equally important. As mentioned above, in accordance with the principle of equivalence of care, which applies for reasons of both preventive health care[21] and serious epidemiological

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Recommendation R (1998) 7; The CPT Standards 2002 (rev. 2011); UNAIDS/UNODC/WHO: HIV/AIDS *Prevention, care, treatment and support in prison settings: a framework for an effective national response*; WHO Europe: *WHO guidelines on HIV infection and AIDS in prisons* (Geneva 1993); Møller L. et al: *Health in prisons: a WHO guide to the essentials in prison health* (Geneva 2007); World Medical Association: *Declaration of Edinburgh on prison conditions and the spread of tuberculosis and other communicable diseases*; UNODC: *HIV prevention and care in prisons and other closed settings: a comprehensive package of interventions*, Policy Brief (Vienna 2012).

19. CDC: *Syringe disinfection for injection drug users* (Atlanta GA 2004).
20. WHO Europe: *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*, Evidence for Action Technical Paper (Geneva 2004).
21. The CPT Standards 2002 (rev. 2011).

need, in countries where needle/syringe-exchange and opiate-substitution programmes for injection drug users are available in the community, they should be made available in prisons as well.

In 2012 there were 74 prisons in eight countries (with well-funded and severely underfunded prison systems) – Switzerland, Germany, Spain, Republic of Moldova, Kyrgyzstan, Romania, Luxembourg and Tajikistan – where needle/syringe-exchange programmes were running in prisons for men and women, of all security levels and sizes, and in some cases had been running for more than 10 years. Various ways of distributing and collecting injection paraphernalia were used: health-care professionals, NGO staff, automated dispensing machines or carefully selected peer inmates. Despite these diversities, the results of these programmes have been remarkably consistent. They have improved prisoners' health, reduced needle sharing and undercut fears of violence. At the same time, there has been no evidence of increased drug consumption or other negative consequences.[22] In countries with high prevalence of HIV among drug users in the community and in prisons, the implementation of needle/syringe-exchange programmes in prison must be regarded as a matter of high priority.[23] Achieving this goal will require leadership and skill to convince the public and politicians of the importance of this harm-reduction method in prison, for the benefit of general public health.

Prevention of other possible causes of blood-borne infections that might prevail in prisons, such as sharing and re-using of tattooing and piercing instruments or razors, and blood-sharing brotherhood rituals, should also be addressed in educational training and/or by appropriate provisions.

Provision of condoms and prevention of sexual violence

International prison research provides evidence that sexual activity in prisons happens all over the world. Most sexual contacts are, understandably, of same-sex nature; they may be consensual or coerced (in the coercive environment of a prison often not clearly distinguishable) and 1-3% of prisoners

22. Prison Needle Exchange: *Lessons from a comprehensive review of international evidence and experience*, 2nd edn, Canadian HIV/AIDS Legal Network (2006); WHO/UNAIDS/UNODC: *Guide to starting and managing needle and syringe programmes: needle and syringe programmes in closed settings* (Geneva 2007).
23. WHO/UNAIDS/UNODC: *Guide to starting and managing needle and syringe programmes: needle and syringe programmes in closed settings* (Geneva 2007).

become victims of rape.[24] The risk of transmission of HIV is highest in violent sexual activities. For several years, most western European countries have provided condoms in prison and there is now clear evidence that condoms, lubricants and dental dams are used in sexual activities by prisoners if they are easily and anonymously accessible, that provision of condoms has not induced an increase of sexual activity in prison and that, because there is no evidence of negative unintended side-effects, condom provision is accepted by most prisoners and staff once it is introduced.[25]

However, condom provision without effective policies to counter sexual violence is clearly insufficient to prevent sexual transmission in prison. Policies to prevent sexual violence must include avoidance of overcrowding, adequate staffing and surveillance, non-tolerance of informal hierarchies among prisoners and structural improvements enabling staff to protect vulnerable prisoners from sexual violence.

In reports on several country visits, the CPT has expressed concern about the lack of condom provision[26] and deficient protection of prisoners from sexual violence.[27]

3.6 Medical preventive interventions

Vaccination

In line with the policy brief of the United Nations Office on Drugs and Crime (UNODC) on HIV prevention and care in prisons and other closed settings,[28] free provision to prisoners and prison staff of hepatitis B vaccination is recommended. It is reasonable to offer hepatitis A vaccination to patients with chronic hepatitis B or C, since additional infection with hepatitis A virus can cause acute fatal liver failure.

24. Jürgens R., Nowak M. and Day M: "HIV and incarceration: prisons and detention". *Journal of the International AIDS Society* 14:26 (2011) .
25. WHO/UNODC/UNAIDS: *Interventions to address HIV in prisons: comprehensive review*, Evidence for Action Technical Paper (Geneva 2007); WHO/UNODC/UNAIDS: *Effectiveness of interventions to address HIV in prisons*, Evidence for Action Technical Paper (Geneva, 2007).
26. CPT/Inf (2005)1; (2007)40; (2011)20.
27. CPT/Inf (2007)32; (2009)8; (2011)22; (2011)24; (2012)9.
28. UNODC: *HIV prevention and care in prisons and other closed settings: a comprehensive package of interventions*, Policy Brief (Vienna 2012).

Antiviral treatments of HIV and hepatitis B/C disease have, in addition to their therapeutic effect, a strong preventive effect by rapidly reducing the virus load in treated patients, who are consequently much less likely to become a source of infection.

Prophylaxis

Less proven, but highly probable, is the preventive effect of post-exposure prophylaxis. Medical consultation and post-exposure prophylaxis treatment should be immediately accessible to victims of sexual violence as well as for prisoners and prison staff after other inadvertent exposure to HIV and hepatitis B/C infection. Prisons should be prepared for such cases by standard operating procedures or guidelines.[29]

29. Ibid.

Chapter 4

The dual epidemic: HIV/Aids and tuberculosis (TB)

HIV/Aids and TB are the greatest killers worldwide among infectious agents.[1] The HIV/Aids epidemic and the concomitant increase in the TB epidemic have been called the dual epidemic or intersecting epidemic, not only because of their chronological and geographic coincidence but mainly because the two diseases and epidemics have a strong negative influence on each other. For both diseases the highest prevalence is found in low-income countries. On a world map, regions with high HIV incidence and prevalence match largely with regions of high TB incidence and prevalence. About one third of the 34 million people living with HIV infection are co-infected with TB and they are about 30 times more likely to fall ill with TB than people with an intact immune system. More than half of all Aids patients manifest TB disease and TB is the most common serious opportunistic infection in HIV patients. Almost 25% of deaths among people with HIV are due to TB.[2]

In addition, there is a newly emerged problem of the increasing drug resistance of TB, and the primary cause is inappropriate TB treatment. In eastern European countries more than 10% of newly infected people are infected with drug-resistant bacilli strains and this rate is of course much higher in previously treated and relapsed patients. The former DOTS strategy (directly observed treatment short course) of the World Health Organization (WHO) had to be upgraded to "DOTS plus" due to the need for additional and more expensive diagnostic equipment along with the extended second-line treatment with more side-effects.[3]

1. WHO Fact sheets (October 2012).
2. Ibid.
3. Ibid.

HIV/Aids and TB infection/disease share many common features, though completely different in the route of transmission.

- They are over-represented in underprivileged populations, thus showing a much higher prevalence in the prison population than in the community. HIV prevalence in prison is up to 25 times and TB prevalence up to 100 times higher than in the community at large;[4] prisons favour both HIV transmission (see previous chapter) and TB transmission; prison conditions such as overcrowding, poor ventilation, weak nutrition and inadequate or inaccessible medical care fan the spread of TB inside prisons; prisons act as TB reservoirs, pumping the disease into the community through staff, visitors and inadequately treated released prisoners; and factors favouring the spread of TB favour also the spread of drug-resistant TB.[5] Hence, prisons must be regarded as epidemiological epicentres for the TB epidemic, just as they are (as mentioned earlier) for the HIV/Aids epidemic: prisons are epidemiological epicentres for the dual epidemic and must be acknowledged as such by the community.
- TB is a poverty-driven disease, and drug addiction in many countries is a major cause of HIV infection, which is also associated with and/or leads to poverty. Both infections, HIV and TB, are accompanied by social stigmatisation and further marginalisation.
- A rapidly increasing number of individual patients are affected by both infections; and, in both infections, T-cell-mediated immunity is affected, so each of them worsens the clinical course of the other. Whereas not more than 10% of immune-competent persons infected with TB develop clinical manifest of the disease, there is a 30 times higher likelihood of manifest of TB disease in HIV-infected persons. The problem is further aggravated by the fact that diagnosis of TB disease in immune-compromised persons is much more difficult than in immune-competent patients because of lower reliability in sputum microscopy diagnosis of infectious pulmonary TB alongside the greater prevalence of extra-pulmonary TB, resulting in less reliable X-ray diagnosis. Moreover, the combined treatment with antiretroviral drugs for HIV/Aids and TB, particularly the treatment of drug-resistant TB, is difficult and challenging due to the many drug interactions and adverse side-effects, and it may be less effective.

4. WHO: *Tuberculosis in prisons* (web page) at www.who.int/tb/challenges/prisons/en/.
5. Ibid.

All the various updated guidelines on control of tuberculosis in prison[6] include:

- the need for TB control in prisons to have the same standards as TB control in the community, to be organised in close co-operation with the health authorities in the community, to be included in the National Tuberculosis Programme and to undergo the same documentation, evaluations and quality assurance,
- improvement of prison conditions by avoiding overcrowding and ensuring good ventilation, access to sunlight, access to health care, placement of prisoners in small units, adequate nutrition and exercise in the open air,
- education and health promotion regarding TB,
- early diagnosis (screening on entry, self-referral, active case-finding),
- separation of infectious patients and contact tracing,
- effective standard treatment, strictly according to the WHO protocols on DOTS and/or DOTS plus,
- continuity of treatment following transfer or release.

Several European countries do not yet comply with such guidelines on TB control in prison. In a number of judgments the European Court of Human Rights found a violation of Article 2 and/or 3 of the ECHR due to deficient care of prisoners with tuberculosis,[7] and prison conditions were classified as promoting the spread of TB and amounting to degrading and inhuman treatment due to overcrowding, lack of ventilation and daylight. Likewise, in recent country visits,[8] the CPT has expressed its concern about deficiencies in TB prevention and care in prisons.

In order to challenge drug-resistant TB and the dual epidemic of HIV/Aids and TB, a number of additional measures are needed.

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6. WHO: *Tuberculosis control in prisons: a manual for programme managers* (Geneva 2000) at WHO/CDS/TB/2001/.281; Møller L. et al: *Health in prisons: a WHO guide to the essentials in prison health* (Geneva 2007); USAID/TBCTA/ICRC: *Guidelines for control of tuberculosis in prisons* (2009); CDC: Morbidity and Mortality Weekly Report, 7 July 2006 (Atlanta GA 2006); CDC: *Prevention and control of tuberculosis in correctional and detention facilities: Recommendations from CDC* (Atlanta GA 2006).
7. *Melnik v. Ukraine* 72286/01; *Malenko v. Ukraine* 18660/03; *Vasyukov v. Russia* 2974/05; *Hummatov v. Azerbaijan* 9852/05; *Logvinenko v. Ukraine* 13448/07; *Makharadze and Sikharulidze v. Georgia* 35254/07.
8. CPT/Inf (2007)42; (2010)12; (2010)27; (2010)30; (2012)24; (2011)26; (2011)29; (2012)17.

- Sputum microscopy has low sensitivity in detecting tubercle bacteria, and classic tuberculosis culture methods give results as much as two months later. For early and sensitive identification of infectious TB and drug-resistant TB, new technologies with rapid detection of tuberculosis bacteria and resistance patterns[9] should be implemented as soon as possible. This is of particular importance in a setting where people are in close proximity, such as prison, because of the need for immediate separation of infected and drug-resistant TB patients and for early treatment according to resistance pattern, in order to interrupt disease transmission effectively. High-sensitivity detection methods for tubercle bacteria are also required because of the low sputum bacteria concentrations in HIV co-infected infectious TB patients.
- In view of the high rate of co-infection with HIV and TB, and in accordance with the WHO policy on the dual epidemic,[10] identification of HIV patients among identified TB patients, and TB diagnostic in identified HIV patients, must be intensified. Owing to their long history with TB, many countries and prison systems have decentralised TB facilities, whereas HIV services are mostly centralised. In order to cope with a dual epidemic, it has been strongly suggested that staff of existing TB facilities in the community and in prison should receive training to provide education on HIV/Aids prevention and voluntary confidential counselling and testing for HIV of their TB patients and that those who test positive should start as soon as possible with cotrimoxazol prevention and be referred for antiretroviral (ARV) treatment.
- Likewise, in identified HIV patients, education in TB prevention, TB infection control and active TB case-finding needs to be intensified. For those exposed to TB infection and/or with latent TB infection, preventive isoniazid (INH) treatment should be considered (provided there is no high prevalence of INH-resistant TB bacteria). HIV patients with diagnosed TB disease must start immediate TB treatment in accordance with the result of their drug-sensitivity testing.

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9. Small P. M. and Pai M: "Tuberculosis diagnosis – time for a game change". *New England Journal of Medicine* 363 (2010), 1070-71; Boehme C. C., Nabeta P., Hillemann D. et al: "Rapid molecular detection of tuberculosis and rifampicin resistance". *New England Journal of Medicine* 363 (2010), 1005-15; WHO Global Tuberculosis Report 2012.
10. *WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders* (Geneva 2012).

Such policies at patient level are to be embedded in a strategy of close co-operation and co-ordination of surveillance, planning, financing and monitoring of combined HIV and TB programmes at international, national, regional and institutional levels. National TB programmes and national HIV/Aids programmes should be closely linked; and prisons, where both diseases of dual epidemic have a much higher prevalence than in the community, must be included in national programmes and initiatives on HIV/Aids and TB.[11]

11. Ibid.

Chapter 5

Psychoactive drugs and the medical management of drug-addicted prisoners

5.1 Psychoactive drugs

There has been no culture in history without psychoactive drugs. They have been used in three ways: for religious or mantic rites, as medicine and "recreationally".

In the old cultures, the knowledge and possession of psychoactive drugs were restricted to privileged persons – priests, shamans and physicians (often one and the same) – holding a powerful position in society. Access to and consumption of psychoactive drugs by non-privileged people was regarded as subversion and was punished by those in power. This explains in part the history of the regulation of psychoactive drugs and the terms "licit/illicit" and "legal/illegal" applied to drugs.

From the medical and sociological point of view, the use of any psychoactive substance entails risks to the individual's health and to society. Consequently, there is a need for regulations in which risks are taken into account. Psychoactive drugs that are currently socially and legally accepted for recreational use, such as tobacco and alcohol, are also subject to regulation to a certain extent (on the roads, in the workplace, for juveniles). However, induced by the massive increase in production, trade, traffic and consumption of psychoactive drugs for recreational use in the 20th century, three UN conventions on psychoactive drugs[1] laid down a strictly prohibitive approach (rather than a regulatory

1. UN Single Convention on Narcotic Drugs 1961; UN Convention on Psychotropic Substances 1971; UN Convention Against Illicit Traffic in Narcotic Drugs and Psychoactive Substances 1988.

approach) to the non-medical use of psychoactive drugs that were defined as illicit drugs. This is also the case in national laws on psychoactive drugs in most countries. As a result, sentences for violation of prohibitive drug laws – and consequently imprisonment rates – have increased dramatically in many countries since the 1960s, without achieving full control of the existence of the black illicit drugs market, with its violence, anarchy and powerful dynamics. It has become apparent now that this approach brought no success in the "war on drugs" and that post-prohibition models of drugs regulation have to be designed.[2]

Looking at the list of socially accepted ("licit") psychoactive drugs (tobacco, alcohol, caffeine, in some countries khat, betel nuts and other substances) and illicit drugs (opiates, cocaine, amphetamine derivatives, cannabis, hallucinogenic drugs, benzodiazepines and others) it becomes clear that:

- the social and legal acceptance of psychoactive drugs varies historically (alcohol prohibition in the 1930s in the USA) and geographically (cannabis sale in Holland, khat accepted in Yemen but not in neighbouring Saudi Arabia);
- the social and legal acceptance of psychoactive drugs does not depend on the magnitude of its health risks: the health damage to individuals, to public health and the impact on the global burden of disease by alcohol and tobacco exceeds by far the health risks of the other psychoactive substances.[3]

Psychoactive drugs are in general classified according to their chemical structure and/or their effect on the central nervous system, with some overlapping of categories: ethylic alcohol, nicotine in tobacco, caffeine, sedatives and hypnotics, cannabinoids, opiates and opioids, cocaine, amphetamines and derivatives, hallucinogens and volatiles. With the exception of caffeine, the chronic use of all groups of the above-mentioned substances is associated with adverse effects on health and the risk of developing dependence. In addition, the emergence of new synthetic psychoactive drugs on the European black drugs market – a steadily increasing phenomenon – is a matter of great concern.[4]

2. Transform Drug Policy Foundation: *After the war on drugs: blueprint for regulation* (Bristol 2009).
3. WHO: *Neuroscience of psychoactive substance use and dependence* (Geneva 2004).
4. EMCDDA: New drugs detected in the EU at the rate of around one per week, say agencies, News Release No. 2/2012 (26 April 2012).

All of them act by attachment to specific receptors in the central nervous system that mobilise neurotransmitters activating or inhibiting neuronal activity in various complex biochemical and electrophysiological patterns at synaptic junctions. With repetitive use of psychoactive substances, receptor up-regulation and an increase in enzyme induction (required for degradation of the drug) form the biochemical basis of tolerance.

Neuroscience and modern imaging techniques that visualise brain activity have shown that three brain areas play a predominant role in the response to psychoactive drugs and the development of dependency: the ventral tegmental area, the mesolimbic dopamine system and the cortex.

All psychoactive substances provoke a rewarding sensation in the same manner and in the same brain areas as the stimuli that are critical to survival, such as feeding and reproduction. Dopamine increase in the mesolimbic dopamine system, the biochemical reaction to all unexpected rewards, has been measured as much higher under psychoactive drugs than under natural stimuli such as food intake. The mesolimbic dopamine system also plays a major role in emotional motivation and reinforcement learning processes, a mechanism that, in combination with neuronal reorganisation – "synaptic plasticity" – for cortical (sensory) and limbic (emotional) projection, may represent the bio-behavioural background of dependency.[5]

5.2 Drug dependency and addiction

Despite such biological reactions increasingly identified by neuroscience research, not everybody who consumes psychoactive drugs becomes dependent on or addicted to psychoactive substances. The term "addiction" relates generally to compulsive behaviour, not only substance-related but also, for example, gambling.

Dependency

There are a number of factors, apart from the chemical structure of a substance and its biological reactions in the brain, that foster the development of drug dependency or drug addiction:

- the substance, its availability, dose, frequency, duration of consumption and route of application, can play a role;

5. WHO: *Neuroscience of psychoactive substance use and dependence* (Geneva 2004).

- developing a disorder of the personality of a drug user may have a profound effect on the likelihood of developing substance addiction: deficient ego development with subsequent weak super-ego control have been seen as responsible for a lack of personal autonomy leading to a behaviour of withdrawing from conflicts and seeking surrogate solutions such as drug use; personality disorders, frequently diagnosed in drug-dependent patients, and a history of abuse in childhood are likely contributors to the development of substance abuse;
- other psychiatric co-morbidity, such as bipolar disorders and schizophrenia, often accompanies drug use and dependency and may have a strong influence on the development of drug dependency. It is known that mental diseases and substance dependency have the dysfunction of the mesolimbic dopamine system in common;
- poor education, social and personal disadvantages, social isolation, unemployment, lack of future prospects and inability to cope with these adverse conditions make (especially young) people susceptible to drug dependency;
- the social environment – the culture and what we call the "subculture" of drug users, full of conduct codes and rites – may contribute;
- there is growing evidence that genetic factors have a significant influence on the development of substance dependency.[6]

Hence, drug dependency is a multifactorial disorder resulting from a complex interplay of individual, psychological, social and neurobiological factors that make a person who is exposed to psychoactive drugs susceptible to developing those persistent neurophysiologic alterations in the brain that are responsible for drug dependency and that make abstinence difficult to achieve in a short time. Based on these persistent brain alterations, substance dependency is a chronic disease and, like other chronic diseases such as diabetes and hypertension, it is characterised by a long course and frequent relapses; it can be treated but rarely cured in the short term.

Addiction

Addiction is described (rather than defined) as "monopolisation of the attention system by addictive stimuli" or "continued compulsive behaviour in spite of the awareness of its adverse health and social consequences". In contrast, there exist very clear diagnostic criteria for drug dependency. According to

6. WHO: *Neuroscience of psychoactive substance use and dependence* (Geneva 2004).

the International Classification of Diseases, Version 10 (ICD-10), a diagnosis of drug dependency should be made if more than three of the following elements are present:[7]

- a strong desire or sense of compulsion to take the substance;
- difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use;
- a physiological withdrawal state when substance use has ceased or been reduced, as evidenced by the characteristic withdrawal syndrome for the substance;
- evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses;
- progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- persisting with substance use despite clear evidence of overtly harmful consequences.

The diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) are, in essence, the same, apart from the additional item "persistent desire or unsuccessful efforts to cut down or control substance use".[8]

Adverse consequences

The adverse health consequences of psychoactive drug dependency include the acute and chronic toxic effects of the drug itself, accidental or suicidal overdose, intoxication, traffic accidents and chronic toxicity, mainly by alcohol and tobacco but also chronic neuropsychiatric conditions of other substance groups. Other adverse health sequels relate to poverty and lifestyle, such as malnutrition, sexually transmitted diseases, tuberculosis and dental problems, or to the route of drug application, such as the blood-borne transmissible infections HIV/hepatitis B and C, bacterial septicaemia, lung abscesses, endocarditis and others in intravenous injectors, or destruction of nasal mucosa in cocaine sniffers and others.

7. WHO: ICD-10 (Geneva 2010).
8. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders* (Washington DC 1994).

The compulsion of dependent drug users is taken advantage of by the drugs market, both the drug market for legally accepted drugs (alcohol, tobacco) and, to a much greater extent, the black market for illegal drugs, with adverse social consequences. Illegality of psychoactive drugs is clearly in the interest of traders and dealers because of the lucrative profit margins that allow traders and dealer to make big money quickly and drive substance-dependent individuals, often already socially disadvantaged, into debt, poverty, social isolation, prostitution, criminality and prison.

In view of these negative consequences of substance dependency and the rising number of substance-dependent patients in many societies, despite the "war on drugs" and the chronic nature of the disorder, the importance of effective harm-reduction measures, as outlined in Chapter 3 on the prevention of spread of HIV/Aids and hepatitis B and C in prisons, should be emphasised.

5.3 Medical management of drug-addicted prisoners

As mentioned (see above, Epidemiological background), up to 30% of prisoners have a history of problematic and/or injecting drug use and it can be estimated that a major proportion of them fulfil the diagnostic criteria for drug dependency or addiction. In order to meet their health-care needs, health-care professionals in prison must identify them during the medical examination on admission, be aware of health emergencies that might occur to these individuals, pay due attention to their particular vulnerability in prison, look for the availability of harm-reduction measures in prison, provide appropriate treatment of drug dependency and arrange in good time their aftercare upon release.

The early identification by health-care professionals of drug-dependent offenders during the medical examination at admission is of particular importance in order to be prepared for the treatment of and support in withdrawal syndromes and for suicide-risk assessment, problems that typically arise shortly after imprisonment. In addition, as was pointed out in the chapter on the medical examination at admission, this opportunity should be used to deliver information and education on blood-borne infections to drug-dependent offenders and to invite them to participate in voluntary confidential counselling and testing for HIV and viral hepatitis.

Medical emergencies in drug-dependent persons include acute withdrawal conditions and, which also occurs in prison, acute drug intoxication. Withdrawal

syndromes, particularly alcohol and benzodiazepine withdrawal, in some cases also opiate withdrawal, can become life-threatening so that intensive care treatment is needed. If the health-care team in prison is not adequately experienced and/or equipped to treat such cases, timely transfer to an appropriate hospital unit must be arranged; otherwise the prisoner's human right to adequate treatment is violated.[9] In this regard it should be remembered that state-of-the-art treatment of opiate withdrawal is opioid-supported detoxification and "cold withdrawal" – withdrawal without adequate medical support – must be regarded as ill-treatment. The medical emergency box of the prison health-care team should be adequately equipped and should, in addition to general resuscitation equipment, contain also naloxone and detoxification drugs.

Vulnerability

Drug-dependent offenders belong to the group of vulnerable prisoners because they rank low in the prisoners' hierarchy and face prejudice both from inmates and from less educated staff. Staff must be educated that substance dependence is not a failure of will or strength of character but a chronic medical disorder often associated with other mental disorders.

The addictive and drug-seeking behaviour of substance-dependent offenders makes them easy victims of violence, coercive sex and other pressures, such as pressure to divert prescribed drugs in opiate-substitution treatment. In trying to acquire drugs in prison they risk getting into debt, with the consequence of threats, bullying and violence. According to the CPT standards, one of the tasks of the health-care professionals in prison is to provide humanitarian assistance, particularly to vulnerable prisoners,[10] and the standards also include recommendations for protection and replacement under the safeguard of medical confidentiality.

Harm-reduction measures

Evidence has shown that drug-dependent offenders continue their risky behaviour in prison and, when harm-reduction measures are not available in prison, they resume or even initiate behaviour that risks transmission of blood-borne infections. Therefore, for epidemiological, medical and ethical reasons, harm reduction in prison is an indispensable requirement. The rationale, concepts

9. *McGlinchey and others v. UK* 50390/99.
10. The CPT Standards 2002 (rev. 2011).

and measures of harm reduction have been described in detail in Chapter 3 on the prevention of spread of HIV/Aids and hepatitis B/C in prisons.

Treatment

Notwithstanding the importance of first exhausting all possible alternatives to imprisonment for drug-dependent offenders, as emphasised above, forced stabilisation during imprisonment can and should be used to offer treatment that, due to their chaotic lifestyle, has not been earlier accessible for them.

Successful treatment needs the full co-operation of the patient. Compulsory treatment of mentally competent drug-dependent patients, although still prevailing in the penal legislation of several countries, is both medically and ethically more than questionable. Drug addiction is a chronic disease prone to recurrences that need long-term treatment, like any other chronic disease.

As outlined above, a major proportion of substance-dependent patients suffer from additional psychiatric co-morbidities that need to be diagnosed and treated properly. It has been clearly shown that pharmacological treatment of co-morbid depressive or schizophrenic disorders is efficacious in the treatment of substance dependency.[11] For pharmacological treatment of other psychiatric conditions, the prescription of benzodiazepines in prison should be handled with great caution and taking them should be controlled visually because of the high risk of diversion, as in the case of prescribed drugs in opioid-substitution treatment.

As the treatment goal of abstinence in opiate addiction is hardly ever achieved in the short run, the orientation of most current treatment concepts has shifted from abstinence strategies to acceptance of drug use alongside harm-reducing treatments which try to stabilise the psychosocial situation of the drug-dependent client, reduce criminality, keep the patient alive and in therapeutic terms reduce adverse health consequences. This works best in combination with oral opioid substitution.

In line with the multifactorial aetiology of substance dependency, there is a wide range of psychological and psychosocial treatment concepts, from various psychoanalytic techniques such as Gestalt therapy to cognitive behavioural therapies such as contingency management, relapse prevention and motivational enhancement techniques. The choice of the best possible psychosocial

11. WHO: *Neuroscience of psychoactive substance use and dependence* (Geneva 2004).

treatment strategy in each prison will inevitably depend on the prevailing resources and experience of the health-care team.

Aftercare

The preparation of and arrangements for support in the community after release are important for any prisoner, but for drug-dependent offenders they are vital: reports from all over the world examining the death rate among drug users after release from prison are excessively high, particularly during the first two weeks after release. Most of these drug users died because of drug-related intoxication by overdosing due to reduced tolerance to opiates after interrupted or reduced supply during imprisonment. Opioid-maintenance substitution treatment has been shown to reduce this risk considerably.[12] Therefore, in addition to arrangements for support in the community after release, such as housing, finances, family problems, education, employment and further mental support,[13] education on the risks of overdosing because of reduced tolerance and, for opiate-dependent offenders, continuation of opiate-substitution treatment upon release from prison, are strongly recommended.

12. WHO Europe: *Prevention of acute drug-related mortality in prison populations during the immediate post-release period* (Geneva 2010).
13. Throughcare Working in Partnership: *Throughcare services for prisoners with problematic drug use: a toolkit*, ed. M. MacDonald et al., European Commission (Brussels 2012).

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