The Right to Health in Prisons: Implications in a Borderless World

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Introduction

The right to health in prison[1] has been recently subject to increased attention, at both national and international levels, with many standards, rules and codes of practice having been defined in order to guarantee the fundamental rights of prisoners and make prisons healthier places for both detainees and staff.

It is now generally recognized that prisoners have a right to health care and to protection against inhumane and degrading treatment. Regardless of the nature of their offence, prisoners are entitled to all fundamental human rights, including the right to the highest attainable standards of physical and mental health. More specifically, they retain the right to a standard of medical care which is at least equivalent to that provided in their broader community.

However, despite some improvements in the conditions of detention, in too many parts of the world rhetoric does not match reality.[2] Minimal standards of living conditions and access to health care for prisoners are often inadequate, if not totally inexistent. Prisons and jails in even the richest and most developed countries are still plagued by severe overcrowding, decaying physical infrastructure, a lack of medical care, security abuses and

corruption, and prisoner-on-prisoner violence. Rates of infection with regards to tuberculosis, HIV and hepatitis are much higher than in the general population, and chronic diseases, especially psychiatric conditions, are often neglected.[3]

International monitors

Various international and regional oversight bodies concerned with human rights systematically investigate and document the living conditions of prisoners. Two UN Human Rights bodies are particularly important to mention: The UN Committee Against Torture (CAT) and the Special Rapporteur on Torture, both of which monitor the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the Working Group on Arbitrary Detention which investigates cases of deprivation of liberty imposed arbitrarily and monitors compliance with the relevant international standards. Since 2006 and the entry into force of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, an international visiting mechanism for the prevention of torture has been set up. To date, 37 of the 62 countries that have signed the Optional Protocol have also ratified it,[4] allowing regular visits on their territory.

Similar mechanisms have been implemented at a regional level, within the member states of the Council of Europe, with the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The Committee, composed of independent and impartial experts from various backgrounds, exerts its control by means of regular visits to different places of detention (e.g. prisons and juvenile detention centres, police stations, holding centres for immigration detainees and psychiatric hospitals). It surveys the conditions of detention and recommends, if necessary, improvements to the states visited.[5]

The work of these international oversight bodies is also supported by a wide range of international non-governmental organizations and civil society actors. Many, like Amnesty International or Human Rights Watch, are engaged in advocacy and raising awareness about human rights violations in places of detention. Others, like the Association for the Prevention of Torture, advocate for legislative reform, ratification and implementation of relevant international treaties. Many of them work closely with states through regular visits to places of detention. Rarely acknowledged, the In-

ternational Committee of the Red Cross (ICRC), under the Geneva Conventions, has developed a long-standing practice of visiting prisoners of war and civilian internees.

The role of health workers

Primary care physicians and front-line workers (nurses) play a central role in prisons and share a direct responsibility to ensure that detainees can exert their right to health as they do for other patients outside the penitential setting.[6] Although medical workers in general do not require knowledge of human rights and law, their ethical duties require them to assume the role of advocates on behalf of their patients. This is particularly true in the closed and isolated environment of prisons, where human rights abuses occur with impunity and where health workers are sometimes the first witnesses of such violations.

This said, health professionals are often unaware of the ethical and human rights framework in which their activity takes place. Moreover, they tend to underestimate the use of legal instruments and litigation as a way to enforce the right to life and to health. Developing an understanding of the right to health does not necessarily entail adopting a different way of working. On the contrary, the right to health could be a practical tool for health professionals that are confronted with human rights issues in their daily clinical practice.[7] Practising medicine in prison requires that clinical competence, which guarantees quality of care, be linked with a sharp awareness of deontology codes and international ethical standards. Innovations and improvements in health services are often the result of interactions between end users, health care providers and policy makers. Protecting the rights of the prison population imposes innovative thinking inspired first by patients' needs and expectations. The accumulated experiences of prison medicine could play a complementary role in documenting situations that could lead to health policy reforms. The systematic screening of violence at prison entry – which explores violence experienced by detainees during arrest or incarceration (violence expert testimony evaluation) – is a good example of how organized epidemiologic and clinical information collection could be used to defend prisoners' rights and improve prison practice.[8] Such operational research, using equity as its conceptual "lens", offers a means of monitoring the relevance and responsiveness of clinical activities in such settings.

This chapter will not review legal instruments or expert recommendations. International human rights standards and legal instruments are used as a reference point that serves as a guide to translating what may be considered abstract theory into practical application in the day-to-day work of health professionals involved in prisons.[9] One of the aims of this chapter is to discuss how front line health care professionals, working in prisons, can contribute to protecting and improving prisoners' rights to health by using medical evidence collected from their daily clinical experiences.

While conditions of detention vary substantially from country to country, and despite the fact that the cases presented here are based on real situations in a remand prison of Switzerland, one of the richest and most developed countries in the world, many of the issues addressed illustrate some important aspects of promoting good health in prisons worldwide.

The chapter will first describe the trajectory of an inmate entering the prison of Champ-Dollon, the remand prison of the State of Geneva, Switzerland, highlighting some important issues that could hamper access to health in prison. We will then use two short stories inspired from our local practice to illustrate some of the daily challenges encountered. The last section will concentrate on the growing number of prisoners worldwide, and, more specifically on the increase of foreign populations in Swiss and European prisons, which constitutes one of the greatest challenges for prison management in Europe. We will discuss the impact of the political environment upon prisoners' health and rehabilitation opportunities. Some recommendations will be proposed in conclusion.

Setting the scene: The medical unit at the remand prison of Champ-Dollon, Geneva, Switzerland

The remand prison of Champ-Dollon is Switzerland's largest prison. Its organization is the result of an interesting legal framework that has been subject to several adaptations.[10]

A special state decree, in force since September 2000,[11] describes the obligations and organization of medical care in prisons. It follows the recommendation of the Committee of Ministers of the Council of Europe (No. R (98) 7 on the Ethical and Organizational Aspects of Health Care in Prison).[12] The total separation of power between the judicial system and health care providers has been central to responding to detainees' health-related rights. Indeed, all medical units responsible for the care of detainees are indepen-

dent of the prison administration and the Cantonal Department of Justice and Police. All are part of the University Hospitals of Geneva, which is under the responsibility of the Cantonal Department of Health.

The prison health services comprise outpatient primary care clinics (one for adult and one for juvenile detainees) as well as inpatient units (one for psychiatric patients, located on the prison grounds, and a second medico-surgical unit, located at the main site of the University Hospital), the overarching mandate being to ensure comprehensive somatic and psychiatric health care.

Prison health staff consist of university-trained rotating physicians and nurses. The interdisciplinary team, comprised of general practitioners, nurses, psychiatrists, psychologists and various specialists, engages in more than 14 500 consultations per year, offering curative and preventive interventions.[13]

Champ-Dollon prison population

Champ-Dollon is sadly notorious for being the country's most overcrowded prison.[14] In 2007, for a normal capacity set at 270, an average of 456 detainees (169% capacity) were incarcerated. 95% were male, and the average age was 30.1 years. Of the 108 national origins, 10.6% were Swiss, 18.7% Eastern European, 18.5% Western European, 18.8% North African, 18.9% sub-Saharan African, 10% Asian and 4.5% American (North and South). In terms of legal status, 62% were undocumented migrants. The length of stay in the prison was less than 1 week for 33% of those incarcerated, less than 1 month for 50% and less than 90 days for 71% of the detainees. In January 2008, Geneva authorities opened La Brenaz, a modern prison on land adjacent to Champ-Dollon, designed to help ease the situation at the neighbouring facility.

Beyond principles: Access to health care in Champ-Dollon prison

The right to health in prison begins with the recognition that, despite having been deprived of their liberty, people in prison retain their fundamental right to good health – both physical and mental – and can expect to receive health care that is at least equivalent to that provided in the wider community. This principle of equivalence is cited in numerous national and international directives and recommendations, the most explicit being the

Recommendation (No. R (98) 7, of 8 April 1998)[15] of the Committee of Ministers of the Council of Europe, and the recent Recommendation (No. R (2006) 2)[16] updating the European Prison Rules.[17]

Along with the principle of equivalence, three other governing principles of the European instrument form the ethical pillars of health care in prison: Confidentiality, informed consent and independence.

Prison medicine in Geneva strives to apply these guiding principles. Effective implementation requires a constant battle to overcome several barriers.

The equivalence of care in prison is a measure of the extent to which a society practices the principle of equality of citizens by providing the same quality and range of care as in the wider community.

The application of this principle also responds to the values of justice and solidarity. However, the characteristics of the prison population and the settings in which care is provided are far from being equivalent to what is provided to the general population. As shown by Niveau, the principle of equivalence is often insufficient to take into account the adaptation of the organization of health care essential to the correctional setting.[18]

Providing care in prison involves working with men and women who have been deprived of their liberty. Many of them are likely to be mentally disturbed, suffer from addictions or other chronic conditions, have poor social and educational skills, and come from marginalized groups in society.[19] Prisoners are more likely to be in a bad state of health when they enter prison and have therefore more health-related needs, and higher consumption of health services, than the general population.[20]

Moreover, assessing health needs is often difficult. Uncertainty regarding judicial decisions, security or disciplinary measures, overcrowding, dirty or depressing environments, poor food, lack of activity, availability of illicit drugs, promiscuity, power struggles and intimidation between inmates and guards, all tend to affect the health of prisoners and their ability to express their needs.

Health evaluation therefore must be more systematic and proactive than in a conventional primary care setting. For this transient, high risk, vulnerable population, medical services offered free of charge offer a unique chance to express a health concern and seek care. Prison health services provide an opportunity to screen and diagnose neglected conditions or symptoms that, if left untreated, may lead to life-threatening conditions (chronic viral hepatitis, insulin-requiring diabetes) and/or may be a cause

of public health concern when the detainee returns to the community (e.g. tuberculosis). Common problems encountered in health care practice are listed in box 01.

Box 01: Common problems in prison health care practice

Physical illness includes:

1. Dependence (drugs, alcohol, tobacco);

2. infections;

3. dental disease;

4. chronic disorders (lung disease, heart disease, diabetes, epilepsy, diseases of the reproductive system, cancer).

Mental health problems include:

1. Low mood or self-confidence (self-esteem and dependence: Drugs or alcohol);

2. anxiety;

3. depression;

4. severe mental disorders.

Co-occurring problems include:

1. "Vulnerable" people (learning disability, brain injury, learning difficulty, for instance resulting from autistic spectrum disorder or Asperger's syndrome or dyslexia; and

2. the nature of the sentence (harm against women, offences against children, bullying or recollection of being a victim of abuse).

Poor general condition includes:

1. Hygiene;

2. nutrition;

3. mobility;

4. personality disorder;

5. physical and mental trauma and stress.

Source: Lars Møller, Heino Stöver, Ralf Jürgens, Alex Gatherer and Haik Nikogosian (eds.) *Health in Prisons: A WHO Guide to the Essentials in Prison Health* (Copenhagen: WHO Regional Office for Europe, 2007), at 26, available at http://www.euro.who.int/document/e90174.pdf. (with permission).

On the other hand, while providing access to health care to all detainees, health professionals working in prisons need to regulate health demands and avoid manipulation by both detainees (overuse) and security staff (limiting access by the regulation of escorts, for example). Moreover, all aspects of health care provision (prevention, diagnosis and treatment) need to be grounded in good medical evidence. This implies integrating evidence-based medicine and the concept of equivalence, rationalizing and taking into account the resources available.

The Champ-Dollon prison offers a wide range of curative and preventive services, some of which were implemented early in comparison to other neighbouring cantons and countries. The prison was one of the pioneer institutions in some pilot projects regarding harm reduction (e.g. methadone substitution, condom distribution, syringe and needle exchanges). On entry to prison, all prisoners are briefly seen by a nurse in order to evaluate their health status and assess whether an urgent medical consultation is necessary. Screening for contagious infections is conducted, as well as screening for violence, mental health problems, and drug and alcohol addiction. The initial assessment also includes medical history, risk factors for communicable infectious diseases (which are more prevalent in this population) such as HIV, hepatitis B and C, and sexually transmitted diseases, and the checking of vaccine status. A general physical examination is performed which includes an appraisal of active signs of drug withdrawal (see case 2) that may warrant a substitutive treatment (e.g. benzodiazepines, methadone maintenance therapy). All health services and screening tests are offered on a voluntary, confidential basis and are free of charge.

Detainees can send a confidential written request to the medical service. In addition, the need for a medical consultation can be assessed by nurses who have regular and direct contact with inmates during their daily rounds while distributing drugs or controlling health parameters (fever, blood pressure, sugar levels). Security staff also relay detainees' health requests and regularly inform the prison health team of health complaints.

All consultations are reported in a personal medical record kept in the medical health unit. According to the same rules as apply in the community, information about medical status, diagnosis or therapeutic measures are not divulged to a third party without the informed consent of the patient. Once a detainee is released, efforts are made to ensure continuity of care with community health services or with a former family doctor. This is particularly important for methadone maintenance therapy or when

chronic treatments for conditions such as HIV or hepatitis infection have been initiated (case 2). Figure 1 summarizes the clinical trajectory of a given detainee entering the Champ-Dollon prison. Table 01 highlights some of the medical conditions that may warrant prompt interventions after the first medical assessment.

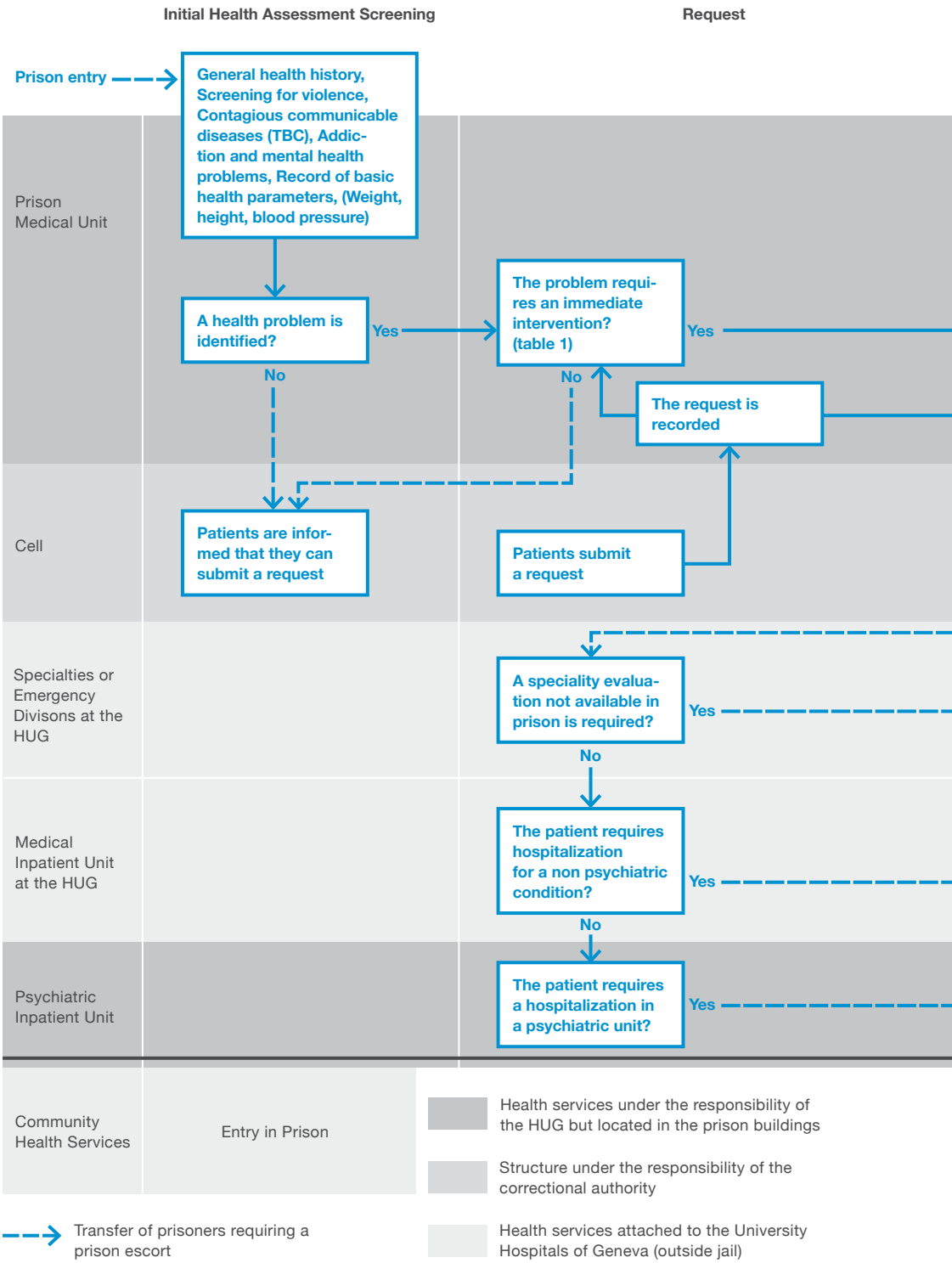
In spite of a legal framework that strongly protects the rights of the detainees, Champ-Dollon still remains a prison which, as such, is a hostile environment for both prisoners and staff, rendering health care and promotion difficult. As in any prison, health is not the primary concern, and the need for security and discipline can cut across a perception of the individual (prisoner) as patient. Consequently, individual movement is restricted and subject to strict rules. In a study on space, place and movement in prison, Stoller describes, through prisoners' narratives, how the spatial organization and structure of the prison can impede movement, and, as such, restrict access to health care.

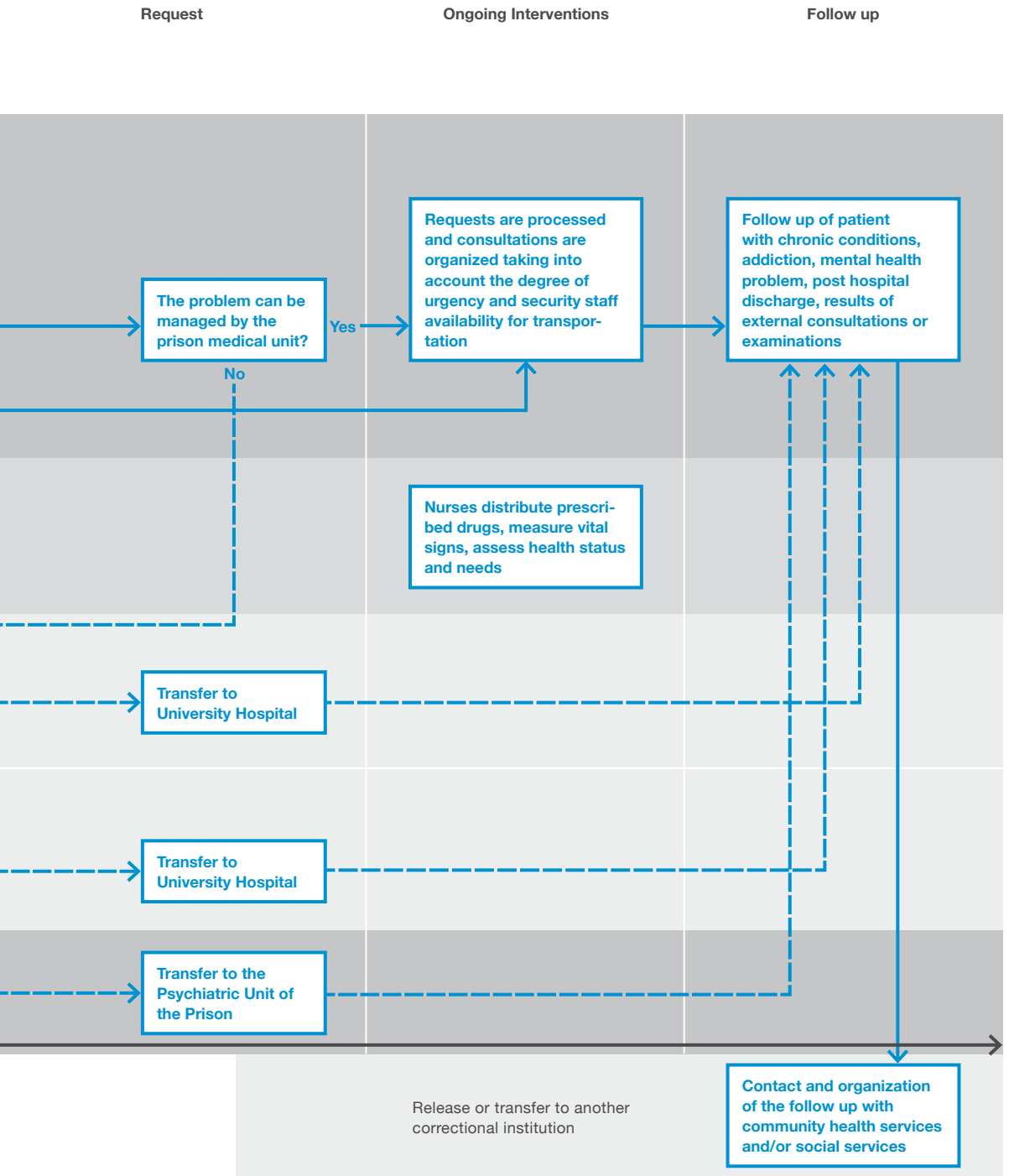
The study highlights that the "spatial organization and structure of the prison reflect management goals in opposition to the putative goals of a

Table 01. Examples of conditions that may warrant urgent health intervention on entry into prison

Condition	Intervention
Contagious infectious disease ex. active tuberculosis	Isolation, transportation to the relevant hospital, treatment started, measures to prevent the propagation of the infection to other inmates and staff
Mental health or addiction problems	Psychiatric evaluation, substitution therapy for addiction (methadone), or transfer to mental health unit (risk of suicide, self-harm)
Trauma during arrest	Allegations of violence are reported, specific exams are performed (x-rays, pictures), treatments are given (stitches for a wound, pain killers)

Figure 01: Trajectory of a given detainee entering the prison of Champ-Dollon




Request
Ongoing Interventions
Follow up
The problem can be managed by the prison medical unit?
Yes
No
Requests are processed and consultations are organized taking into account the degree of urgency and security staff availability for transportation
Follow up of patient with chronic conditions, addiction, mental health problem, post hospital discharge, results of external consultations or examinations
Nurses distribute prescribed drugs, measure vital signs, assess health status and needs
Transfer to University Hospital
Transfer to University Hospital
Transfer to the Psychiatric Unit of the Prison
Release or transfer to another correctional institution
Contact and organization of the follow up with community health services and/or social services

committed health care provider. Where humanistic health practice requires an acknowledgment of interconnectedness, prisons are based on principles of exclusion, separation, and confinement."[21]

Figure 01 (dotted arrows) shows that any medical act in Champ-Dollon can only take place if the detainee is brought out of his cell to the medical health unit or to a medical structure outside the prison. Although medical staff can come and go to their clinics, they cannot enter a prisoner's cell without a guard accompanying them, a situation that may compromise confidentiality.

Once in the prison medical unit, detainees are held in closed cells, awaiting their turn to see the health staff, or to return to their cell with other inmates. These physical constraints are perhaps one of the best illustrations of how health provision in prison differs from the outside world. As pointed out by Stoller:

> "Prison clinics are also nested. A correctional health service can incorporate a medical culture within its doors, but staff and prisoner/patients can only access the clinic and the culture by moving through the prison in which the clinic is nested. This means that the nature of prison as a place inevitably affects a clinic within it, if only through the feelings, attitudes, and beliefs that those traversing the prison bring as they enter the doors of the clinic. Beyond any subjective impact, the walls, barbed wire, locks, and rules of a prison further separate the nested clinic both literally and metaphorically from the wider medical community."[22]

Bars, walls and locks are not the only barriers to health care in prison. As described in our first case study here below, health care can be continually thwarted by rules, custodial priorities and poor communication, especially for prisoners in need of mental health care.

Case study 1

Natig Amirov (fictive name) was arrested at the border carrying cocaine in his body (bodypack). He comes from Azerbaijan and speaks Azeri and Russian. He has had no contact with his family since his incarceration. He became quite familiar to the medical team as he had been brought in several times for self-harm and a suicide attempt. He suffers from a severe depression for which he is on medication, but with poor compliance. His

detention was marked by incidents involving security staff, who registered him as being a "hard to handle" with "an oppositional behaviour". His self-aggression contributed to his further isolation in the prison, other inmates being reluctant to share a cell with him. Condemned to three years imprisonment, he was about to be transferred to another prison to serve his sentence when he was brought again to the medical unit after a scarring of his right forearm. Mumbling words in Azeri, the detainee was escorted by two guards who showed obvious signs of irritation. On this busy Monday afternoon with numerous prison escorts to the medical unit, Amirov's repeated self-injury exacerbated the tensions due to the workload among the medical and the security staff who do not understand why Amirov was not on "a good medication that would calm his pathological self–aggressive tendencies".

As none of the staff spoke Azeri or Russian, the doctor and the nurse, after taking care of the wound, tried to explain to the patient, in German, that in order to protect him from any further attempt to self-injure during the night (as there was only one nurse on duty for more than 450 inmates), he would be transferred to the prison psychiatric unit where closer observation would be possible. Filled with anxiety, the prisoner started shouting and crying. He was brought forcefully to a closed cell in the medical unit to await his transfer to the psychiatric unit. Once in the closed cell, he knocked repeatedly at the door before being tartly called to order by the guards who opened the cell, shouting at him, and finally pushed him back violently to the floor. Nobody from the medical team dared to intervene or say a word. The patient was then transferred to the psychiatric unit.

Case discussion

This case study illustrates how prisoners with mental illness, poor literacy or facing language barriers, are more prone to fail to access effective health care and may be subject to isolation, abusive acts, racism or indifference by medical and security staff.

Mental health problems and suicide are known to be more prevalent among prison inmates.[23] Before entering prison, prisoners with mental health conditions often belong to the most vulnerable groups of society. Unemployment, low levels of education and homelessness are frequently associated social conditions. Substance abuse is also common before and in prison, and many of the offences that lead to imprisonment are drug

related. In addition, substance abuse and dependency are frequently associated with known mental illnesses or personality disorders, creating an additional challenge for their management. Moreover, a review of the medical history of mental health offenders often reveals traumatic life events (e.g. violent or sexual assaults, living in disaster or conflict areas, and previous history of imprisonment). This is particularly true for prisoners who are migrants, who may have experienced significant stressful events and may have related pathologies often left undiagnosed before their incarceration (e.g. post-traumatic stress disorder[24] or Ulysses syndrome[25]).

Psychosis, major depression, and antisocial personality are the most common mental disorders encountered in prisons. A systematic review of 62 surveys from 12 different western countries reviewed the prevalence of psychiatric disorders among the prison population.[26] A total of 22 790 prisoners (mean age 29 years, 81% men) were included. Of the male prisoners reviewed, 3.7% had a psychotic illness, 10% major depression and 65% a personality disorder. Of the female prisoners reviewed, 4% had a psychotic illness, 12% major depression and 42% a personality disorder. These disorders are often chronic and do not lend themselves easily to therapeutic interventions.

The prison environment also creates new mental problems and further exacerbates previous ones. While in prison, nearly all prisoners experience depressed moods or stress symptoms. Anxiety and sleep disorders are the most frequent complaints, for which psychotropic drugs are requested.

At an individual level, all aspects of life in prison affect the mental health of prisoners. Prison takes away liberty, autonomy, breaks familial ties and damages self-esteem. Rules and regulations within prisons do not marry well with mental disorders. Breaches in discipline by prisoners experiencing an acute psychiatric deterioration or a nervous breakdown are often the source of incidents and create tensions among staff, as illustrated by the case discussed above.

Depressive patients, or those experiencing impulsive or aggressive behaviour due to their illness, suffer the most from the monotony of the daily routine, the restrictions imposed on their movement, and the lack of activities available. Self-harm becomes a stereotypical way of reducing tension and symbolically restores a sense of control over one's self. This is particularly true when language barriers reduce the ability of the detainees to express themselves, as was the case with the Azeri patient in the case study above.

In this regard, intercultural communication, both verbal and non-verbal, is the backbone of all facets of everyday life in prison. Optimal communication between the three actors involved in the triangular relationship formed by the patient-detainee, the security guard and the health care worker constitutes a prerequisite to good health in prison. In this case study, the language barrier hampered basic communication, created tension and fear among inmates and staff, and further exacerbated the medical condition (self-harm episodes, violence perpetrated by staff). The final violent event is the result of poor communication by both security and medical staff. Providing the necessary translation/interpretation services at the times they are needed is often problematic. The inability of the medical team to provide understandable information to the patient contributed to his anxiety and agitation, and indirectly contributed to the violent measures taken by the guards.

As will be discussed further, the presence of large groups of foreign inmates in Swiss and European prisons creates an additional challenge for both health professionals and prison administration to deliver appropriate healthcare and respond to the health needs of this population.

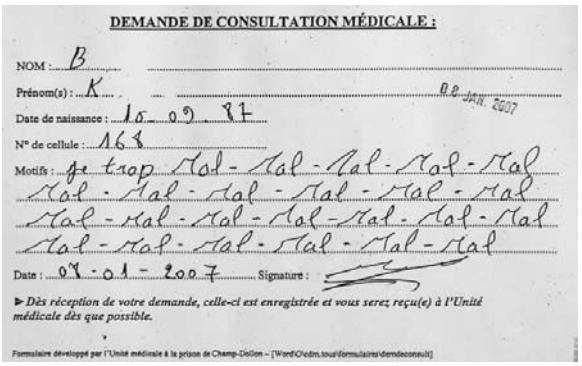
Achieving health care continuity is another important objective of health professionals working in prison. It requires that a prisoner with a given health problem or disability achieves continuity of health care as he or she moves back to the community. The second case study illustrates the difficulty of meeting this objective.

Case study 2

M. B. K. originally from North Africa, an undocumented migrant, 28 years of age, has sent a written request to the medical unit (see illustration 01):

> "Je trop mal-mal-mal-mal-mal … [I'm too ill-ill-ill-ill-ill …]"

M. B. came to Geneva 6 years ago "because living was too difficult in Algeria". Since then, he earns money from dealing heroine and cocaine, lacks health care insurance, and sleeps frequently in shelters for the homeless. His drug dependency started in Algeria. In the past, he required admission to the emergency department several times, once even to the intensive care unit for a drug-related coma. When entering the prison, he was seen by the nurses who suspected a withdrawal syndrome, and asked a general practi-



DEMANDE DE CONSULTATION MÉDICALE :

NOM : B

Prénom(s) : K

Date de naissance : 16 09 87

N° de cellule : 163

Motifs : je trop Mal - Mal - Mal - Mal - Mal Mal - Mal - Mal - Mal - Mal - Mal Mal - Mal - Mal - Mal - Mal - Mal - Mal Mal - Mal - Mal - Mal - Mal - Mal - Mal

Date : 09 - 01 - 2007 Signature :

► *Dès réception de votre demande, celle-ci est enregistrée et vous serez reçu(e) à l'Unité médicale dès que possible.*

Formulaire développé par l'Unité médicale à la prison de Champ-Dollon – [Word\Ocdm.tous\formulaires\demdeconsult]

01

tioner (GP) to see him immediately. The GP confirmed a withdrawal syndrome with irritability, diffused muscular pain, secretions of the nose and goose-pimples. He received a substitution therapy (methadone). As prisoners with heroine withdrawal are at high risk of overdose after release, the GP convinced the detainee to keep up the substitution therapy during incarceration. He also recieved information about withdrawal clinics in town where he could go after release.

Furthermore, an active Hepatitis C infection was diagnosed during the first two weeks of incarceration. As the sentence of M. B. was not yet known, no antiviral treatment was prescribed. This treatment (2000 CHF/month) has to be taken for at least 6 months and his sentence was likely to be less than 4 months. M. B. was released a few days later. Time did not allow for contact to be established with the health care centre for undocumented migrants or with the withdrawal centre.

Case discussion

Today's migratory trajectories are becoming more complex and diversified. In Switzerland, scientific studies have shown that various aspects of the health of members of the migrant population are worse than that of the local population. Whatever the reason and type of migration (voluntary migration, forced or economic), migrants are exposed to greater health risks and find it harder to access the services of our health care system.[27]

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Written request sent by an inmate to the medical unit of the remand prison of Champ-Dollon, Geneva
"I am too ill, ill, ill, ill…".

This is particularly true for undocumented migrants or failed asylum-seekers, who are often reluctant to seek assistance in public health services due to lack of financial means or fear of the immigration authorities.[28] Despite the fact that undocumented migrants residing in Switzerland can receive insurance from the public health insurance system if they fulfil the general conditions (residence in Switzerland and payment of premiums), many of them are not aware of their rights and do not use public health services unless there is an emergency.

For this vulnerable population, access to health services is, paradoxically, easier while in prison. Imprisonment offers an opportunity to screen and diagnose what are often severe physical and mental illnesses that contribute to their precarious social situation.[29] The neutral space of the medical consultation allows migrants to express past sufferings related to their migratory trajectory, often marked by harsh living conditions, difficult losses and grief.

Medical services offered free of charge represent an additional incentive for these individuals to seek care, many of them being generally unable to pay medical fees or medicines in the outside world.

Providing health care to this population necessitates a close collaboration with many actors of the community health services. A good knowledge of the network and a comprehensive health and social needs assessment plan allows for a correct orientation of the patient during his incarceration and after release.[30] Pre-existing relations with community health services or health professionals that are based simultaneously in the jail and in the community can enhance such collaboration.[31]

Continuity of health care is only possible when a discharge plan is set up well in advance.[32] This is a condition that is rarely met in remand prisons where most inmates are released on short notice without a set medical appointment. Even when release can be anticipated, costly treatments and the lack of health insurance can further impede access to health care.

Furthermore, in Switzerland, the recent tightening of immigration laws has reduced the social security benefits and emergency aid that failed asylum-seekers could once claim.

Since sentenced undocumented migrants or failed asylum-seekers can be repatriated after release under immigration law and/or penal law, continuity of care for this group is often difficult to maintain. This discontinuity may lead to poor health outcomes, overuse of emergency health services and recidivism (drug trafficking).[33]

In the last case described, the interruption of treatment (methadone maintenance therapy) will most likely be followed by a relapse with drug injection and a risk of overdose.[34] Indeed, the risk of death from overdose may be greater for injecting drug users who resume drug use after a period of abstinence, during which their tolerance may have declined. Overdose is the leading cause of death in the immediate period after release from prison.[35]

These selected case studies depict two foreign prisoners. Our choice was not made by chance or only to illustrate a deprived and vulnerable group. With a proportion of around 70%, Switzerland is among those European countries with the highest rates of foreign prisoners. This trend is not unique to Switzerland, and many other countries see their prisons filled with foreign nationals. The reasons behind this phenomenon are complex and far beyond the scope of this chapter. Improvements in communication and travel possibilities, increased transnational trade activities, migration accentuated by economic crises or conflicts, are all factors that contribute to globalized criminalization. As we will discuss in this last section, the global prison population worldwide is increasing and becoming more heterogeneous. This continuously changing body of inmates constitutes one of the most challenging issues prison facilities will have to manage in the coming years.

The prison population grows

Prisons are no longer at the margins of our society. Over 9 million people are held in penal institutions throughout the world, mostly as pre-trial detainees (remand prisoners) or having been convicted and sentenced. Almost half of these are in the United States (over 2 million), China (1.5 million) or Russia (0.9 million).[36] According to the World Prison Population List (2007), prison populations are growing in many parts of the world. In comparison with the 2005 and 2006 figures, the Prison Population List shows that prison populations have risen in 64% of the countries in Africa, 84% in the Americas, 81% in Asia, 66% in Europe and 75% in Oceania. Key facts on Swiss prisons are summarized in box 02. This increase in the numbers of detainees and the use that we make of imprisonment poses several questions for the kind of society that we aim to be, as well as the role given to any criminal justice system to best serve society. If the main purposes of prisons are to punish criminals, as well as to rehabilitate them, we still need to make sure that this should only be done for the most serious crimes

and when there is no reasonable alternative. Yet in all countries prisons are filled with marginalized groups: The poor, the unemployed, the homeless, the mentally ill or ethnic minorities.

Box 02: Swiss prison population-key facts

In September 2007, 5715 people were in prison for a total capacity of 6654 places. 1653 people were being held in detention. A further 3586 were serving time, while 403 were waiting to be expelled from the country. The 73 others were being held for a variety of reasons. Prisons were 86% full, with the vast majority of detainees being adult males. Women accounted for 6% of the prison population, and teenagers 1%.

Source: Federal Statistics Office, Prisons' census, September 2007.

The confusion between really dangerous criminals and those offenders who have a mental illness, a history of drug abuse, or marginal lifestyle, contributes to maintaining, both in government planning and in the eyes of the public, the perception that the best response to insecurity is more emphasis on imprisonment.

Speaking in December 2004 at the launch of the report by the UK Parliamentary Joint Committee on Human Rights into Deaths in Custody, the Chairperson, Jean Corston MP, noted:

> "Crime levels are falling but we are holding more people in custody than ever before. The misplaced over-reliance on the prison system for some of the most vulnerable people in the country is at the heart of the problems that we encountered … Extremely vulnerable people are entering custody with a history of mental illness, drug and alcohol problems and potential for taking their own lives. These people are being held within a structure glaringly ill-suited to meet even their basic needs."[37]

At a time when many countries, including Switzerland, are engaged in reforms to limit the use of imprisonment as a measure of punishment, the general tendency to emphasize questions of security and migration control tends to restore the original notion of prison as a place for the exclusion of specific subgroups of individuals.

Particularly alarming is the overrepresentation of particular groups in society, especially detainees of foreign origin or ethnic minorities. For example, a 2000 report of Human Rights Watch[38] revealed that out of a total population of 1 976 019 incarcerated in adult facilities in the United States, 1 239 946 (or 63%) are African-American or Latino, though these two groups constitute only 25% of the national population. In the UK, between 1999 and 2002 the prison population increased by 12%, while the number of black prisoners increased by over 54%.

Foreign nationals: A new marginalized group in prison populations

In recent years, a new marginalized group has emerged that contributes to the increase of prison populations: Foreign nationals. This phenomenon has become a worrisome reality for several European countries. In 2006, there were more than 100 000 foreign prisoners in European countries.[39] Their numbers vary greatly per country. In Switzerland, around 70% of all prisoners are foreign nationals. In Austria, Belgium, Cyprus and Greece there are over 40%, while in Estonia, Italy, Malta and the Netherlands the proportion is over 30%. The average percentage of foreigners in the prison population of the countries of the European Union is over 20%.

Over the last decades, in addition to the considerable growth of the EU prison population, populations have also changed significantly. Prison populations throughout Europe are characterized by a wide variation of nationalities, religions and cultural backgrounds. In many countries, over 100 different nationalities are represented in prison. This shift of composition remains a major challenge for prison staff in their daily interactions with prisoners, notably with regard to issues such as the multiplicity of languages, religious practices, or food preferences. This raises fundamental questions concerning the capacity of these institutions to provide culturally adapted information regarding rules, obligations and rights.

Until recently, the causes of this growing proportion of foreign nationals in prisons and the impact of this growing heterogeneity on the professionals involved (prison employees, decision-makers in administration and politics) have not received much attention.[40]

Particularly revealing is a one-year project on foreign prisoners in European penitentiary institutions co-funded by the European Commission in 2005. Based on the collaboration of several experts working in the field, the objective of this project was to address the issue of social exclusion of

prisoners who are detained in the EU outside their country of origin. Its aim was to study and analyse their situation in 25 European Union (EU) Member States, to exchange information among experts, to identify innovative approaches and to develop recommendations to combat their social exclusion.[41]

Despite the diversity of the criminal systems and penitentiary services studied, the report underscores the overrepresentation of foreign prisoners in European penitentiaries and reports several common trends:

1. EU national laws and immigration control regulations tend to lead to a concentration in prison of individuals with foreign citizenship, and, increasingly, undocumented immigrants, resulting in a higher application of deprivation of liberty, at the level of both remand custody and sentencing for this population.

The combination of criminal and administrative procedures tend to create a "double sentence" where foreign prisoners have a greater tendency to be incarcerated, spend more time in prison, benefit less from non-custodial measures or other forms of sentence alleviation (prison leave, conditional release) and have less access to measures of reintegration (work, professional training).[42] This is particularly true for undocumented immigrants. This issue has recently been recognized by the European Directors of Prison Administration, as one of the most pressing challenges faced by prison administrations in Europe. During an international conference organized in Vienna, in November 2007, under the theme of "Managing Prisons in an increasingly complex environment", two representatives of the Austrian Penitentiary Administration made the following remarks:

> "A growing part of prisoners consist of non-citizens in an elementary sense, of scantly tolerated displaced persons who lack rights of asylum but cannot be repatriated. They are affected by a number of measures of aliens police, ranging from ban of residence and custody pending deportation to deportation. Legal procedures including the proceedings for the enforcement of deportation usually take a long time. Pending proceedings mean insecurity for all parties, for prisoners as well as for the administration, they render prisoners incalculable and hamper a prison regime which approximates normal life conditions. In fact these prisoners live in a legal no man's land and they remain – whatever the nature of their offence – in double custody. First in prison and in addition under an alien's

police regime that adheres to a quite different logic than that of imprisonment on remand or penal custody with its perspectives of rehabilitation and reintegration."[43]

2. The lack of social integration for many foreign prisoners is often seen by actors of the criminal justice system to enhance the risk of criminality or recidivism, resulting in a higher application of deprivation of liberty.

The absence of legal status and residence for many foreign prisoners is seen by the judiciary apparatus as enhancing both the risk of absconding and the risk of recidivism.[44] The risk of escape often being taken for granted, foreign prisoners – particularly those without residence permits – are incarcerated in closed prisons. The poor socioeconomic and financial situation of many foreign or ethnic minority offenders, as well as a higher prevalence of mental health disorders and drug dependency in this population, are again seen as enhancing the risk of recidivism.

3. Foreigners or ethnic minorities face different problems during detention, ranging from severe language and communication problems, to religious or cultural conflicts or racism.

Daily interactions between prisoners and staff are seriously hampered if prisoners do not speak any of the local or common languages (case study 1). These communication constraints are the source of tensions or conflicts among inmates sharing cells or with security staff.

A lack of migrant-friendly health care contrasts with the current efforts put in place in the community. Indeed, providing culturally adapted health care has, in recent decades, become a priority for many countries. In 2002, for instance, the EU Commission created the European migrant-friendly hospitals (MFH) pilot project, which invites all European hospitals to develop into transculturally competent organizations. In Switzerland, several strategies have been developed since the early 1990s. Based on a vision of equal opportunity, the Federal Office of Public Health launched, in spring 2007, the "Migration and Public Health Strategy: 2008–2013", the second phase of the national strategy. Among the achievements of the first phase, 500 interpreters were trained and certified according to defined standards. They are now employed in health institutions throughout the country. Despite these improvements, having translation available in prison is still a challenge in practice. Even when available, many interpreters are reluctant

to offer their services in the prison environment, where security rules make any external intervention difficult. International telephone companies who offer translation/interpretation services in more than 100 languages and dialects could be an alternative. Internet-based translation software might provide some help too.

Health care provision in prison also has cultural connotations, which could be hampered by inadequate communication. As presented by De Viggiani:[45]

> "Prisoners 'import' values, attitudes, beliefs and social norms from their respective communities (...) Today's prisons are not completely closed systems. They have permeable boundaries and transient populations and represent microcosms of the wider society. Prisoners' backgrounds and biographies, therefore, contribute to their abilities to cope with and survive imprisonment."

Intercultural misunderstandings, prejudices and stereotypes, which see certain national groups as representing a higher risk of criminality, are common in prison.

Summary and recommendations

Various forms of action are being taken by the international community to address health care and social justice issues in prisons. This chapter is not exhaustive. Drawn from our daily practice, the issues and examples described illustrate only a few of the critical aspects of health care provision in these particular environments. We have presented some of the guiding principles regulating health care in prison, showing the daily challenges we face in implementing them. We have also highlighted how health professionals working in prisons face problems that are different from those faced by colleagues that work with the ordinary population. In the last section on foreign prison populations in Europe and Switzerland, we have illustrated the growing challenge of meeting the right to health in a globalized world.

Whatever diverse prisons may be worldwide, health professionals involved in prisons share a direct responsibility to make sure that the right to health is properly enjoyed. Adhering to standards of good practice, they should first provide quality health care in a manner that is independent and equivalent to what is prevalent in the community. For this to take place,

continual professional training, adapted to the exercise of the profession in prison settings, and including courses on human rights and ethics in prisons, should be encouraged. Pre-graduate and continuous medical education, using concrete situation-based learning, like the case studies presented, could serve to better integrate the human rights and ethical framework into the daily practice of health professionals.

In addition to their clinical tasks, health professionals working in prisons should demonstrate the capacity to diversify their roles to better meet the health needs of the vulnerable prison population with which they are in contact on a daily basis. This could include taking part in the policy debate to make prison health a public health priority, and/or being involved in collaborative research. Systematic data collection on the health situation in prisons could be an important contribution, and a means to inform prison administrations and policy makers. Where possible, professional associations should work to ensure that health professionals are aware of the channels through which they can draw attention to the information they have identified and documented. Professional associations also need to provide doctors with the support and legal backing to speak out against incidences of abuse, neglect or torture whenever its members encounter such situations and provide support in case of litigation with the prison authorities. Increased and closer collaboration with prison administrations, civil society organizations and community health services could help health professionals working in prisons to raise awareness about the human rights issues encountered and to better coordinate and plan the provision of health care in prison.

1 The term prison is usually applied to an institution holding convicted felons who are serving sentences of more than one year. In this chapter the term "prison" refers to all places of detention including police stations, remand prisons (in the United States (US): jails), or penitentiaries (US: prisons). Remand prisons (or jails in US) ordinarily hold both detainees and persons convicted of misdemeanours who are awaiting trial or serving sentences of less than one year.

2 Human Rights Watch, Global Report on Prisons: 1993 (New York: Human Rights Watch, 1994), available at http://hrwpubs.stores.yahoo.net/globreponpri.html. Human Rights Watch's most recent reports relating to prison conditions, prison abuses, and the treatment of prisoners, are available at http://www.hrw.org/advocacy/prisons/hrw-reports.htm; European Institute for Crime Prevention and Control, *World Prison Population: Facts, Trends and Solutions* (Helsinki: European Institute for Crime Prevention and Control, 2001), available at http://www.heuni.fi/uploads/6mq2zlwaaw3ut.pdf.

3 Lars Møller, Heino Stöver, Ralf Jürgens, Alex Gatherer and Haik Nikogosian (eds.) *Health in Prisons: A WHO Guide to the Essentials in Prison Health* (Copenhagen: WHO Regional Office for Europe, 2007), available at http://www.euro.who.int/document/e90174.pdf.

4 The status of ratification of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment is available at http://www2.ohchr.org/english/bodies/ratification/9_b.htm.

5 Under the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT delegations have unlimited access to places of detention. They also have the right to unrestricted access inside secure units and can interview detainees in private. The last periodic visit (5th visit) to Switzerland took place in autumn 2007. It was one of 11 that the CPT undertook in 2007. Other countries include Spain, the Netherlands, Croatia and Moldova. After each visit, the CPT sends a confidential report containing its conclusions and recommendations to the country concerned. Preliminary observations by the CPT after its last visit to Switzerland are accessible at http://www.cpt.coe.int.

6 Roger Watson, Anne Stimpson, Tony Hostick, 'Prison Health Care: A Review of the Literature' 41(2) *International Journal of Nursing Studies* (2004) 119–28; Louise Condon, Gill Hek, Francesca Harris, 'A Review of Prison Health and Its Implications For Primary Care Nursing in England and Wales: The Research Evidence' 16(7) *Journal of Clinical Nursing* (2007), at 1201–1209; Watson, *supra* note 6; Dave Beer, Bruno Gravier, 'Primary Care in a Detention Environment' 2(88) *Revue Médicale Suisse* (2006), at 2690–2696; Bertrand D, Niveau G (eds.) *Médecine, Santé et Prison* (Chêne-Bourg: Editions Médecine & Hygiène, 2006).

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8 Dominique Bertrand, Laurent Subilia, Daniel S. Halpérin, Romano La Harpe, Jean-Marc Reymond, Donatella Bierens de Haan, Louis Loutan, 'Victims of Violence: Importance of Medical Testimony for the Practitioner' 87(12) *Praxis* (1997), at 417–420.

9 Prisoners, whatever the nature of their offence, retain all those fundamental rights to which they are entitled as human persons, including the right to enjoy the highest attainable standards of physical and mental health. Specific international instruments set out more clearly what this implies in terms of the healthcare provision to be

made by prison administrations. These instruments include: The International Covenant on Economic, Social and Cultural Rights, Article 12; the Basic Principles for the Treatment of Prisoners, Principle 4; the Basic Principles for the Treatment of Prisoners, Principle 9; the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, Principle 24; the Standard Minimum Rules for the Treatment of Prisoners, Rule 22; Standard Minimum Rules for the Treatment of Prisoners, Rule 25; the Standard Minimum Rules for the Treatment of Prisoners, Rule 62; the UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Rule 1; the Health Professionals Association's declarations, including The World Medical Association Declaration of Edinburgh on Prison Conditions and Spread of Tuberculosis and other Communicable Diseases, Preamble; and the International Council of Nurses Position Statement on Nurses' Role in the Care of Detainees and Prisoners.

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11 Etat de Genève. Arrêté du Conseil de l'Etat, (entré en vigueur le 27.09.2000). Documents des HUG. Santé et soins en milieu carcéral. Référence Aml/2.4.4 publié le 12.04.2005.

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16 Council of Europe. Committee of Ministers, 'Recommendation No. R(2006) 2 of the Committee of Ministers to Member States on the European Prison Rules' (2006), available at https://wcd.coe.int/ViewDoc.jsp?id=955747.

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