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RIGHT TO A HEALTHY PRISON ENVIRONMENT: HEALTH CARE IN CUSTODY UNDER THE PRISM OF TORTURE

JUAN E. MÉNDEZ*

INTRODUCTION

In 2011, advancements in international law and correctional science drove the United Nations General Assembly to establish an intergovernmental expert group to assess best practices and to revise the United Nations Standard Minimum Rules for the Treatment of Prisoners (Standard Minimum Rules).[1] During my term as the Special Rapporteur on Torture, I was able to observe the work of the expert group and review the scope and application of the Standard Minimum Rules. In 2013, I presented to the General Assembly my Interim Report on the Standard Minimum Rules from the perspective of prohibiting and preventing torture or other ill-treatment, which both as a matter of law and of policy should be applied to all cases of deprivation of liberty. I also emphasized areas of the Standard Minimum Rules that required revision to reflect developments in international law.[2] In 2015, the General Assembly adopted the new United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), a revision and update of the Standard Minimum Rules. The United Nations Office on Drugs and Crime and a few highly specialized international non-governmental organizations continue to address implementation of the Nelson Mandela Rules to improve prison conditions, prison management, and the humane treatment of prisoners.[3] I have been encouraged by the support that my report has received and by the

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[1] Economic and Social Council Res. 663 C (XXIV), Standard Minimum Rules for the Treatment of Prisoners (Jul. 31, 1957); Economic and Social Council Res. 2076 (LXII), Standard Minimum Rules for the Treatment of Prisoners (May 13, 1977).

[2] Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), *Interim Report of the Special Rapporteur on Torture and other Cruel, Inhuman and Degrading Treatment or Punishment*, U.N. Doc. A/68/295 (Aug. 9, 2013) [hereinafter *Interim Report*].

[3] G.A. Res. 70/175, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) (Jan. 8, 2016) [hereinafter The Nelson Mandela Rules]; OSCE, ODIHR & PRI, *Penal Reform International, Guidance Document on the Nelson Mandela Rules, Implementing the United Nations Revised Standard Minimum Rules for the Treatment of Prisoners* (2008).

growing momentum that has since developed to increase the reflection of these Rules in State practice.

The premise that has guided these developments—and should continue to do so—is that States must respect and fulfill the right to a humane and dignified existence of any person under its custody. Thus, States shall be accountable for the torture and cruel, inhuman, or degrading treatment suffered by persons held in detention facilities. In this regard, authorities should execute prompt and diligent investigations, followed by the prosecution of alleged perpetrators, and ensure that victims receive satisfactory remedies and adequate reparations.

I. FROM STANDARD MINIMUM RULES TO NELSON MANDELA RULES

It is critical first to note that over the past few decades, the worldwide prison population has significantly increased,[4] a phenomenon that has placed an enormous financial burden upon States. Imprisonment has become a near automatic response to crime, rather than a last resort. Penitentiary systems in most countries are no longer aimed at reformation and social rehabilitation, but rather are focused on punishment through deprivation of liberty.[5] As such, the international community's commitment to the revised Standard Minimum Rules, or Nelson Mandela Rules, is critical to the task of protecting and respecting prisoners' inherent dignity and fundamental rights.

The principle of humane treatment of persons deprived of liberty is the starting point for any consideration of prison conditions and prison regimes. Since 1955, the Standard Minimum Rules have reflected this principle and guided State practice on the treatment of prisoners and management of penitentiary institutions.[6] Though the Standard Minimum Rules have in large part withstood the test of time, advancements in correctional sciences and best practices drove the need to revise the rules. In 2012, pursuant to a request from the United Nations General Assembly, an Expert Group was formed to review the Standard Minimum Rules; they continued their work until reaching a consensus in March 2015.

During the Expert Group's review process, I presented my report in 2013, which examined nine areas identified by the Expert Group. My report provided recommendations through the perspective of prohibiting and preventing torture or other ill-treatment. The areas included: (1) scope and application of the Rules; (2) respect for prisoners' inherent dignity and value as human beings; (3) medical and health services; (4) disciplinary action and punishment; (5) solitary confinement; (6) investigation of all deaths in custody, as well as any signs or allegations of torture or inhuman or degrading treatment or punishment of prisoners; (7) right of access to legal representation; (8) complaints and independent oversight; and (9) training relevant staff to

[4] It is estimated that there are over ten million prisoners in the world, and prison populations are growing on each continent. *See* Roy Walmsley, *World Prison Population List (eleventh edition)*, WORLD PRISON BRIEF; INST. FOR CRIM. POL'Y RES. (2015).

[5] *Interim Report, supra* note 2, ¶ 50.

[6] The Nelson Mandela Rules, *supra* note 3, pmbl.

implement the Rules.[7] This article briefly addresses a few of these areas, as they apply to a healthy prison environment.

II. CONDITIONS OF DETENTION

Prison conditions that are characterized by structural deprivation and non-fulfilment of rights necessary for a humane and dignified existence amount to a systematic practice of inhuman or degrading treatment or punishment. While prison systems are almost universally underfunded, this cannot be an excuse for not refurbishing detention facilities, purchasing and issuing basic supplies, or providing food and medical treatment. More specifically, situations that lead to cruel, inhuman, or degrading treatment or punishment, and even to torture, result from overcrowding, lack of ventilation, poor sanitary conditions, prolonged isolation, holding suspects incommunicado, non-separation of different categories of prisoners, and holding persons with disabilities in environments that include areas inaccessible to them.[8] This list of unacceptable conditions is, of course, not exhaustive.

To ensure the safety of prisoners and to prevent physical, sexual, or emotional abuse, the Special Rapporteur recommended that States allocate adequate resources, including proper training of authorities and staff.[9]

III. MEDICAL CARE AND HEALTH SERVICES IN PRISON

Medical care is a minimum and indispensable requirement for ensuring humane treatment of prisoners. Medical care and treatment, including examinations, must be carried out promptly, independently, and consensually. Medical examinations should be administered upon a person's admission to a place of detention and after every transfer between facilities, then thereafter upon a routine basis. Regular medical examinations constitute a basic safeguard against ill-treatment.[10] Moreover, medical examinations are also a key tool in corroborating or refuting allegations of physical and psychological mistreatment.

Additionally, my 2013 report emphasized the need for the revised Rules to expressly recognize how all persons deprived of liberty must always have access to adequate health care: medical, psychiatric, and dental.[11] Further, the report noted the importance of revisiting the concepts of rehabilitation and re-education, as well as corrective and correctional policies and practices, in order to protect persons from arbitrary intervention or treatment that may amount to torture or ill-treatment.[12] When there has been an allegation of torture or ill-

[7] *Interim Report, supra* note 2, ¶¶ 27–84.
[8] *Interim Report*, *supra* note 2, ¶ 45.
[9] *Id.* ¶¶ 36, 88(h).
[10] *Id.* ¶ 50.
[11] *Id.* ¶ 54.
[12] *Id.* ¶ 40.

treatment, prison authorities must investigate such allegations, and if the investigation confirms the abuse, then victims should be guaranteed both rehabilitation and redress.[13]

In revising the Standard Minimum Rules, the Expert Group adopted provisions to ensure both the standard and availability of health care and to adhere to the professional ethics of medical and health care professionals, including an absolute prohibition of professionals to engage in torture or ill-treatment and an obligation to document and report any cases that come to their attention.[14] Provision of basic supplies and medical treatment directly relates to the fundamental and universal rule mandating that persons deprived of liberty must be treated with respect for their dignity, and the revised Rules reflect this fundamental right through emphasizing humane conditions.

Rules 24 through 35 of the Nelson Mandela Rules specifically address health services with regard to prisoners. The revised Rules recognize State responsibility for providing prisoners with health care, and detail the scope and application of health care services in prisons. "Prisoners should enjoy the same standards of health care that are available in [their] communit[ies]," and that care must be free of charge and dispensed without discrimination on the grounds of their legal status.[15] Rule 25 calls upon States to ensure that there is a health care service in every prison, "tasked with evaluating, promoting, protecting, and improving the physical and mental health of prisoners."[16] The rule also provides that such services staff interdisciplinary teams with full clinical capacity and qualified expertise in psychology, psychiatry, and dentistry.[17]

Prisoners' medical files should be kept confidential and made available to all prisoners or a third party of the prisoner's selection upon request.[18] Moreover, in cases of emergency, prisoners should have access to prompt medical attention and be transferred to specialized institutions to receive proper care.[19] The Rules also elaborate on the responsibilities of health care professionals, including the standard and duty of care as well as the need to undertake medical examinations in full confidentiality.[20] Prisoners must enjoy procedural safeguards to protect them from torture or other ill-treatment. Health care professionals are required to document and report any case where they suspect torture or ill-treatment.[21] All prisons and detention centers must be regularly inspected for conditions such as "*(a)* quantity, quality, preparation, and service of food; *(b)* [adequate] hygiene and cleanliness of the institution and the prisoners; *(c)* [t]he sanitation, temperature, lighting and ventilation of the prison; and *(d)* [t]he suitability and cleanliness of prisoners' clothing and bedding."[22]

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[13] *Id.* ¶ 65.
[14] The Nelson Mandela Rules, *supra* note 3, at r. 34.
[15] *Id.* at r. 24.
[16] *Id.* at r. 25.
[17] *Id.*
[18] *Id.* at r. 26.
[19] *Id.* at r. 27.
[20] *Id.* at r. 30–32.
[21] *Id.* at r. 34.
[22] *Id.* at r. 35.

IV. WOMEN AND OTHER VULNERABLE PERSONS IN PRISON OR DETENTION

Adopting special measures to address the particular health needs of persons belonging to vulnerable or high-risk groups is critical to maintaining healthy prison environments. Rules 28 and 29 of the Nelson Mandela Rules are particularly important in recognizing States' obligations to ensure special arrangements for mothers and children born in prisons. Women prisoners who are pregnant require special accommodations for prenatal and postnatal care and treatment.[23] Rule 29 echoes the Convention on the Rights of the Child and states that a decision to allow a child to stay with his or her parent in prison shall be based on the best interest of the child.[24]

These provisions and their corresponding State obligations are significant because of the increase in the number of women being sent to prison.[25] Women as a demographic are the most rapidly growing prison population around the world, while the prison systems continue to be run as originally designed—that is, to hold adult male inmates.[26] Approximately 80% of women prisoners are mothers.[27] Many female prisoners are low-income single mothers or primary caregivers, with their imprisonment often resulting in considerable hardship for their children.[28] Contact between detained mothers and their children can be challenging because of the remote location of female prisons, but concern about their children is one of the primary reasons for the high incidence of mental health problems and self-harm among female detainees.[29] The non-violent nature of crimes committed by the majority of women, and the minimal risk to the public posed by most female offenders,[30] make them prime candidates for non-custodial sanctions, rather than remaining incarcerated and experiencing torture or other ill-treatment.

When trying to access abortions, many women suffer humiliating treatment by doctors, hospital administrators, prosecutors, and other officials, even in places and under circumstances in which abortions are legal.[31] This humiliating treatment often derives from the social stigma surrounding abortions, and States are responsible for finding ways to protect women from this humiliation, which is a form of degrading treatment. Girls in the criminal justice system are at particular risk of experiencing torture and ill-treatment. Girls' physical and mental health needs often go unrecognized, and

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[23] *Id.* at r. 28.

[24] *Id.* at r. 34; Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3.

[25] Maria Eva Dorigo, *Mothers Behind Bars: Reflecting on the Impact of Incarceration on Mothers and their Children*, *in* GENDER PERSP. ON TORTURE: L. AND PRAC. 239, 242 (2018).

[26] Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 16, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016) [hereinafter *2016 Report*]; *see also* Office of the United Nations High Commissioner for Human Rights (OHCHR), *Women and Detention* (2014), https://www.ohchr.org/Documents/Issues/Women/WRGS/OnePagers/Women_and_Detention.pdf.

[27] Dorigo, *supra* note 25.

[28] *Id.* at 245.

[29] *Id.* at 242–245.

[30] *Id.* at 253; *see also* United Nations Office on Drugs and Crime (UNODC), *Handbook on Women and Imprisonment* 104 (2014), https://www.unodc.org/documents/justice-and-prison-reform/women_and_imprisonment_-_2nd_edition.pdf.

[31] *See 2016 Report*, *supra* note 26.

incarceration itself tends to exacerbate existing trauma, with girls suffering disproportionately from depression and anxiety and exhibiting a higher risk of self-harm or suicide than boys or adults.[32] Furthermore, housing girls in the same detention facilities as adults or boys and employing male guards in girls' facilities significantly increase the risk of abuse and violence, including sexual violence.[33]

Lesbian, gay, bisexual, transgender, and intersex (LGBTI) persons who are deprived of their liberty are also at particular risk of torture and ill-treatment, as criminal justice systems tend to overlook their specific needs. LGBTI detainees report higher rates of sexual, physical, and psychological violence on grounds of their sexual orientation or gender identity than the general prison population, with fear of reprisals and lack of trust in complaint mechanisms, frequently preventing them from reporting abuses.[34] A report of the United Nations Special Rapporteurship on Torture underlined a well-defined link between the criminalization of LGBTI persons and homophobic and transphobic hate crimes, police abuse, community and family violence, and stigmatization.[35] At least seventy-six States around the world have laws criminalizing consensual same-sex relationships between adults, with the death penalty imposed in some cases; these laws are not only a breach of the rights to non-discrimination and privacy but foster a climate in which violence against LGBTI persons by both State and non-State actors is condoned and met with impunity.[36]

Members of sexual minorities are disproportionately subjected to torture and other forms of ill-treatment because they fail to conform to socially constructed gender expectations. Indeed, discrimination on grounds of sexual orientation or gender identity may contribute to the process of the dehumanization of the victim, which is often a necessary condition for torture and ill-treatment to take place. For example, LGBTI persons are subjected to ill-treatment by health professionals performing genital-normalizing surgeries under the guise of "reparative therapies."[37] The requirement that a transgender individual be sterilized as a prerequisite for legal recognition also constitutes ill-treatment under international law.[38]

The compulsory detention of drug users and other marginalized groups, including street children, persons with psychosocial disabilities, sex workers, homeless individuals, and tuberculosis patients, in so-called drug treatment or

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[32] *Id.* ¶ 29; *see also* Therese Rytter & Andrea Huber, *Women in the Criminal Justice System and the Bangkok Rules*, *in* GENDER PERSP. ON TORTURE: L. AND PRAC. 217, 230 (2018).

[33] Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 48, U.N. Doc. A/HRC/28/68 (Mar. 5, 2015) [hereinafter *Thematic Report on Children Deprived of Liberty*].

[34] Jean-Sébastien Blanc, *Crime and Multiple Punishments: The Vulnerability of LGBTI Persons in the Criminal Justice System*, *in* GENDER PERSP. ON TORTURE: L. AND PRAC. 199, 205 (2018).

[35] *2016 Report*, *supra* note 26, ¶ 15.

[36] *Id.*; Blanc, *supra* note 34, at 200–20.

[37] Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 76, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) [hereinafter *Thematic Report on Abusive Practices in Healthcare Settings*].

[38] *Id.* ¶¶ 78–79.

rehabilitation centers, is a serious world-wide problem.[39] Many of these individuals are placed in these centers without having received medical evaluation, judicial review, or right of appeal. While in these centers, individuals frequently experience physical violence and humiliation and are subjected to practices that amount to torture and ill-treatment under the guise of rehabilitation and treatment, such as forced labor, physical disciplinary exercises in the form of military-style drills, and electroshock therapy.[40] These practices violate international human rights law and are illegitimate substitutes for evidence-based measures, such as substitution therapy, psychological interventions, and other forms of treatment given with full informed consent.

Additionally, for persons with disabilities, lack of reasonable accommodations may increase the risk of exposure to neglect, violence, abuse, and ill-treatment. Therefore, my report on the review of the Standard Minimum Rules noted how such discriminatory treatment may inflict severe pain or suffering and may constitute torture or other ill-treatment.[41] Further, persons with disabilities are particularly affected by forced medical interventions, and continue to be exposed to non-consensual medical practices, some of which amount to torture or ill-treatment under international law. Individuals with psychosocial and intellectual disabilities frequently experience powerlessness and are stigmatized, which facilitates the potential occurrence of abuses.[42] Medical treatments of an intrusive and irreversible nature, if they lack therapeutic purpose, constitute ill-treatment when enforced or administered without the free and informed consent of the person involved.[43] Ultimately, the importance of adopting revisions to the Rules to provide special measures aimed at protecting the rights of women and vulnerable persons cannot be over-emphasized. States must take special care to ensure that segregating members of these groups does not further marginalize them or further expose them to the risk of torture or ill-treatment.

V. ISTANBUL PROTOCOL AND NELSON MANDELA RULES

Another key instrument related to the treatment of prisoners is the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, also known as the Istanbul

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[39] *Thematic Report on Thematic Report on Abusive Practices in Healthcare Settings*, *supra* note 37, ¶ 40; *see also* UNAIDS, *Do No Harm: Health, Human Rights and People Who Use Drugs* 37 (2016), http://www.unaids.org/sites/default/files/media_asset/donoharm_en.pdf; Human Rights Watch, *Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia, and Lao PDR* 4 (2012) [hereinafter *Torture in the Name of Treatment*].

[40] *Id.* ¶ 41; Roxanne Saucier & Daniel Wolfe, *Privatizing Cruelty—Torture, Inhumane and Degrading Treatment in Non-Governmental Drug Rehabilitation Centers, in* TORTURE IN HEALTHCARE SETTINGS: REFLECTIONS ON THE SPECIAL RAPPORTEUR ON TORTURE'S 2013 THEMATIC REPORT 123, 128, (Center for Human Rights & Humanitarian Law 2014).

[41] *Interim Report, supra* note 2, ¶ 67.

[42] *Thematic Report on Abusive Practices in Healthcare Settings*, *supra* note 37, ¶¶ 40, 63, 65; *see also Torture in the Name of Treatment*, *supra* note 39, at 15.

[43] *Thematic Report on Abusive Practices in Healthcare Settings, supra* note 37, ¶¶ 31–35.

Protocol.[44] The Istanbul Protocol explicitly notes that health care professionals "must observe" the Nelson Mandela Rules and provide medical and psychiatric services without discrimination to all prisoners who require treatment.[45]

Also of particular interest are the Ethical Standards specified in the Istanbul Protocol, and the dual role that a professional might confront in detention settings.[46] Some medical professionals can have dual obligations: to their patients and to their employers. The Protocol recognizes the dilemmas arising from these dual obligations, particularly when professionals are "working with the police, military or other security services, or in prisons," when the interests of employers and their non-medical colleagues may be in conflict with the best interests of the detainee patients.[47] However, the Protocol affirms that

> [w]hatever the circumstances of employment, all health professionals owe a fundamental duty to care for the people they are asked to examine or treat. They cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly.[48]

During my mandate as the Special Rapporteur on Torture, from 2010 to 2016, I also emphasized the need for independent medical professionals in the context of forensic doctors who often serve under law enforcement or security agencies. In these cases, it should be mandatory for the detainee to receive an independent and impartial assessment.[49] In my country visits—on which I was always accompanied by a highly qualified forensic doctor—we found that forensic evidence of torture was severely lacking around the world. There seemed to be a tendency to avoid doing forensic examinations, to produce flawed or even fraudulent reports, or to disregard them in the rare instance when serious reports were present. In response to these observations, in 2014, I published a thematic report on the importance of independent and properly collected forensic evidence in efforts to combat impunity for torture. The proper implementation of the high standards in the Istanbul Protocol and use of independent forensic evidence are vitally important to effectively investigate, prosecute, and punish torture and ill-treatment.[50]

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[44] U.N. Office of the High Commissioner for Human Rights (OHCHR), *Istanbul Protocol Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol")* (2004).

[45] *Id.* ¶ 52.

[46] *Id.* ¶ 83.

[47] *Id.* ¶ 66.

[48] *Id.* ¶ 66.

[49] Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), *Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 73, U.N. Doc. A/69/387 (Sept. 23, 2014).

[50] *Id.* ¶ 37.

CONCLUSION

Respect for the dignity of prisoners is a fundamental right, intrinsically linked to States' obligations to maintain a healthy environment for persons deprived of liberty. A healthy environment requires structural integrity of prison systems, access to medical care and treatment, health care services, including dental, psychological, and rehabilitative services, and opportunity for prisoners to exercise.

For women prisoners and other vulnerable persons, prison systems must recognize and provide necessary special arrangements for the safety and wellbeing of such persons. Additionally, health care professionals play a critical role in detecting and documenting instances of torture, and it is vital that all health professionals be trained in the Istanbul Protocol to utilize it properly. It can be vital to the fate of victims of torture and can transform a health professional's role from one of not only therapist but also advocate for victims.