UNITED NATIONS
HUMAN RIGHTS
SPECIAL PROCEDURES
SPECIAL RAPPORTEURS, INDEPENDENT EXPERTS & WORKING GROUPS

Mandate of the Independent Expert on the enjoyment of all human rights by older persons

ADVISORY OPINION OF INTER-AMERICAN COURT OF HUMAN RIGHTS ON THE RIGHTS OF OLDER PERSONS DEPRIVED OF THEIR LIBERTY

Submission of the UN Independent Expert on the enjoyment of all human rights by older persons to the Inter-American Commission

I. Statement of identity and interest

1. This brief is being submitted by Claudia Mahler, in her capacity as the United Nations Independent Expert on the enjoyment of all human rights by older persons, appointed by the Human Rights Council to begin serving on 1 May 2020, pursuant to HRC Resolution 42/12.

2. The present submission is made to the Inter-American Commission towards requesting an Advisory Opinion by the Inter-American Court of Human Rights on "*Differentiated Approaches to Persons Deprived of Liberty*" under Article 64(1) of the American Convention on Human Rights. The brief is provided on a voluntary basis without prejudice to, and should not be considered as a waiver, express or implied, of the privileges and immunities of the United Nations, its officials and experts on mission, pursuant to the 1946 Convention on the Privileges and Immunities of the United Nations.

3. The Independent Expert on the enjoyment of all human rights by older persons confirms that, in full accordance with her independence, she did not seek or receive authorization from the United Nations, including the Human Rights Council and the Office of the High Commissioner for Human Rights, or any of the officials associated with those bodies, for the positions and views expressed in this submission.

4. The Independent Expert, Claudia Mahler (Austria), has been working for the German Institute for Human Rights as a senior researcher in the field of economic, social and cultural rights since 2010. She is also a visiting professor at the Alice Salomon Hochschule in Berlin. From 2001 to 2009, Ms. Mahler conducted research at the Human Rights Centre of the University of Potsdam where her main fields were in human rights education, minority rights and the law of asylum. In 2000, she was appointed Vice President of the Human Rights Commission for Tyrol and Vorarlberg. She has also worked as a lecturer in the field of human rights law and as a consultant to OHCHR in Geneva. From 1997-2001, she held the position of an assistant at the Leopold-Franzens-University Innsbruck, Austria in the field of Criminal Law and Criminal Procedures and received her doctoral degree in 2000.

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II. Statement of international law on the human rights of older persons

5. On 27 September 2013, by its resolution 24/20, the Human Rights Council created the mandate of the Independent Expert on the enjoyment of all human rights by older persons. The mandate recognized the challenges that older persons face related to the enjoyment of all human rights, and the fact that those challenges require in-depth analysis and action to address protection gaps. Pursuant to resolution 24/20, the Independent Expert was requested to assess the implementation of existing international instruments with regard to older persons. The mandate was institutionalized by Human Rights Council resolution 33/5 on 29 September 2016 and further extended for another three years in 2019 by Human Rights Council resolution 42/12.

6. The creation of the mandate of the Independent Expert on the enjoyment of all human rights by older persons, by the Human Rights Council in 2013, constituted a paradigm shift from a predominant economic and development perspective to ageing to the imperative of a human rights-based approach that views older persons as subjects of law, rather than simply beneficiaries, with specific rights, the enjoyment of which has to be guaranteed by States.

7. The 2012 report of the United Nations High Commissioner for Human Rights to the Economic and Social Council (E/2012/51 and Corr.1) contains a thorough analysis of existing international instruments and gaps in the protection regime. It concluded that existing arrangements to protect the human rights of older persons were inadequate and that dedicated measures to strengthen the international protection regime were required, such as a new dedicated international instrument and/or a new special procedure mandate.[1]

8. Similarly, the Open-ended Working Group on Ageing concluded at its sixth session, held in 2015, that the existing mechanisms designed to guarantee the full exercise of the civil, political, social, economic and cultural rights of older persons have flaws.[2] A variety of proposals have been made with regard to new instruments and measures, in accordance with the Working Group's mandate, including a dedicated convention or an optional protocol to an existing convention.

9. The lack of a comprehensive and integrated international legal instrument to promote and protect the rights and dignity of older persons has significant practical implications, given that: (a) existing regulations do not cohere, nor conceptualize regulatory principles to guide public action and the policies of Governments; (b) it is difficult to clarify the obligations of States with respect to older persons; (c) procedures for monitoring human rights treaties generally ignore older persons; (d) current instruments do not make the issues of ageing visible enough, which precludes the education of the population and with it, the effective integration of older persons.[3]

10. Pursuant to paragraph 6 of Human Rights Council resolution 24/20, the Independent Expert presented a comprehensive report to the Council its thirty-third session.[4] The report covered all aspects of the Independent Expert's mandate and constituted a first global status determination of the human rights situation of older persons, based on information collected and an analysis of implementation gaps and best practices. It highlighted a number of areas in which more in-depth analysis and continued monitoring of developments is required to ensure

[1] *Cf.* E/2012/51, para. 66.
[2] A/AC.278/2015/2, p. 8.
[3] A/HRC/27/46, para. 31.
[4] A/HRC/33/44.

the promotion and protection of the human rights of older persons. The Independent Expert also called on States to step up their efforts to determine the best way to strengthen the protection of the human rights of older persons and to consider the various proposals that have been made, notably the elaboration of a convention on the human rights of older persons.

III. General obligations of States to ensure adequate detention conditions for older persons

11. In line with the request of the Inter-American Commission on Human Rights, the present brief is limited to an analysis of the imprisonment of older persons ordered by a judicial authority as a result of involvement or presumed involvement in the perpetration of offenses or violations of the law. The focus is therefore on the deprivation of liberty of older persons within the prison system, under prison authorities, and that is characterized by a prolonged stay in prison. Therefore, this submission does not consider other situations of deprivation of liberty of older persons, such as in police detention centres, in the custody of administrative authorities, that are generally of a transitory nature.

12. Human rights law does not preclude imprisonment of older offenders. The incarceration of older persons, however, raises a number of human rights concerns, in particular whether the imprisonment conditions are compliant with human rights and whether the conditions are proportionate and adequate.

13. In this context, it is essential to take into account both, the notion of relativity of old age as a social construct and the significant heterogeneity of older persons as an age group. Chronological age (e.g. 60 years and older) as single criterion to define an older person does neither correspond to the biological age (e.g. degree of fitness) and nor does take into account life-course factors and complex realities of a persons' life (e.g. in protracted emergencies or extreme poverty). Experiences of multiple chronic physical and/or cognitive health conditions and physical disabilities at relatively young ages as well as experiences of profound stress and/or trauma over their lifetime, a history of substance use disorder and/or homelessness, and limited access to quality health-care and education can lead to an early-onset medical and social complexity leading to accelerated ageing.[5] To account for accelerated ageing, many jurisdictions consider individuals in their 50s to be *older prisoners*.[6]

14. Moreover, older persons constitute the most heterogeneous of all age groups. While some older persons will become increasingly dependent requiring support from others in old age for several reasons — such as illness, impairments or loss of mobility — and may require varying degrees of specific care, others may be in good health and may be able to live independently or autonomously throughout their lives, particularly if adequate attention is paid to their specific requirements.[7] Therefore, an individualized approach is needed to adequately assess and respond to the needs of older prisoners. This should include due consideration of the multiple and intersecting forms of discrimination that older prisoners may be exposed to while

[5] *Cf*. Ron H. Aday, Aging Prisoners: Crisis in American Corrections, Praeger, Westport, CT, 2003.
[6] A/HRC/45/14, para. 36; Médecins sans frontières, "Older people in crises: A review of MSF's approach to vulnerability and needs", available at www.msf.org.uk/sites/uk/files/older_people_in_crisis_final_oct_2012.pdf, p. 4; *Cf*. Brie A. Williams, Marc F. Stern, Jeff Mellow, Meredith Safer and Robert B. Greifinger, "Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care", American Journal of Public Health, Vo1. 102, No. 8, 2012.
[7] See for instance A/HRC/39/50, para. 6.

deprived of their liberty, as, for example, an older LGBTI prisoner may have specific needs in terms of safety and security.

15. Whereas no specific standards have been adopted in relation to the treatment of older prisoners, the United Nations Principles for Older Persons, adopted by General Assembly resolution 46/91 of 16 December 1991, provide general principles, which apply to the rights and needs of all older persons, covering the principles that should guide policies and programmes developed for older prisoners. The Principles today remain the sole global - albeit soft – standard dedicated to older persons:

> Independence
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> 1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
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> 2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
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> 3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
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> 4. Older persons should have access to appropriate educational and training programmes.
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> 5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
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> 6. Older persons should be able to reside at home for as long as possible.
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> Participation
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> 7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
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> 8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
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> 9. Older persons should be able to form movements or associations of older persons.
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> Care
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> 10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
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> 11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
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> 12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
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> 13. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
>
> 14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their

dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfilment

15. Older persons should be able to pursue opportunities for the full development of their potential.

16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

16. In particular, Principle 12 of the United Nations Principles for Older Persons recognizes the rights of older persons to be autonomous. It requires correctional professionals not to act in an arbitrary manner and to respect the autonomy of older prisoners.

17. In addition, the United Nations Standard Minimum Rules for the Treatment of Prisoners apply to all prisoners, without discrimination, including older prisoners. The *Standard Minimum Rules for the Treatment of Prisoners* were first adopted in 1955 and approved by the United Nations Economic and Social Council in 1957. They have become the key international standard governing the treatment of prisoners and the key framework for monitoring and inspection bodies engaging in assessment activities. On 17 December 2015, the UN General Assembly adopted the *Revised Standard Minimum Rules for the Treatment of Prisoners* (the *Nelson Mandela Rules*[8]) encompassing a targeted revision of terminology and of eight particular areas, including the respect for prisoners' inherent dignity; medical and health services; disciplinary measures and sanctions; investigations of deaths and torture in custody; protection of vulnerable groups in prison settings; access to legal representation; complaints and independent inspection; and training of staff.

18. Rule 2 of the Five 'Basic Principles' that underpin the entire set of *Mandela Rules*, in particular provides that:

1. The present rules shall be applied impartially. There shall be no discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or any other status. The religious beliefs and moral precepts of prisoners shall be respected.

2. In order for the principle of non-discrimination to be put into practice, prison administrations shall take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings. Measures to protect and promote the rights of prisoners with special needs are required and shall not be regarded as discriminatory.

[8] A/RES/70/175 not only adopted the revised United Nations Standard Minimum Rules for the Treatment of Prisoners, but also approved that they should be known as the "Nelson Mandela Rules" in order to honour the legacy of the late President of South Africa, who spent 27 years in prison in the course of his struggle referred to above.

19. The equality of treatment and access to services covered in the *Mandela Rules* imply that prison authorities are obliged to take affirmative action to ensure the equal access of the most vulnerable groups in prison settings, including older prisoners, to all prison facilities and programmes.[9] Particular services may therefore be available to older persons that would not necessarily be available to the general prison population. This is not, however, a demonstration of preferential treatment or discrimination against the majority. It is the responsibility of the authorities to ensure that all practices and procedures within the prison take into account that older persons in prison settings may face enhanced risk and susceptibility to rights violations.

IV. The right to accessibility and personal mobility in detention centers for older persons deprived of liberty

20. Most prisons were designed to restrict the liberty of young persons and not to provide optimal care for older persons. As a result, correctional facilities are often ill-equipped to meet the requirements of older persons, particularly those with complex medical conditions and disabilities, including long-term physical, mental, intellectual or sensory impairments.

21. Some common challenges older prisoners face include difficulties associated with the prison layout and the detention conditions. The facilities often require residents to cope with challenging environmental features such as poor lighting, steep staircases, dimly lit walkways, high bunk beds and low toilets. Difficulties and obstacles such as accessing sanitary facilities, upper bunk beds, excessive heat or cold, are all factors that not only have an adverse disproportionate impact on older prisoners but may also amount to human rights violations preventing older persons from accessing basic services.

22. Due to architectural barriers, prisoners with mobility impairments may be unable to access dining areas, libraries, sanitary facilities, work, recreation and visiting rooms. Prisoners with visual impairments may not be able to read their own mail unassisted or prison rules and regulations. Some may require taped materials or documents and books to be provided in Braille. Prisoners with a hearing or speaking impairment may be denied interpreters, making it impossible for them to express themselves and exercise their rights, including participating in counselling programmes, as well as their own parole and disciplinary hearings. Prisoners with disabilities can be routinely denied participation in work programmes outside prison, sometimes significantly lengthening their periods of imprisonment.[10] Such practices discriminate against older prisoners with disabilities as in many prison systems, the participation in programmes allow prisoners to gain 'credit' for early releases.

23. Older Prisoners with disabilities not only encounter difficulties in accessing services and participating in prison activities that do not take account of their individual requirements, but also complying with rules, for instance due to visual, hearing and other impairment, which leads to an intensified discrimination in prisons, unless specific measures are being taken.

24. Prisons are also often unable to fulfil the general accessibility requirements for older persons with various types of disabilities. Similarly, prisons and prison staff are usually not equipped to recognize and deal with older prisoners who have cognitive health conditions. The ageing prison population in many countries suggests that the number of older persons with

[9] UNODC, Handbook on Prisoners with special needs Handbook, 2009, p. 131.
[10] Ibid, p. 45.

disabilities in prison will rise and their individual requirements will increasingly have to be considered and complied with.

25. The *Mandela Rules* have been revised and updated to reflect the situation and individual requirements of prisoners with disabilities and to ensure that they have full and effective access to prison life on an equal basis, and are treated in accordance with their health requirements. Older prisoners with various types of disabilities will have particular disability related support requirements that prisons might not be adequately equipped to accommodate, including for instance wheelchairs, canes and orthotics, sign language interpreters, captioning, and information in formats that are accessible (e.g. easy-to-read versions or Braille) to older persons who suffer from visual impairments or those with complete loss of sight.[11]

26. Rule 5(2) of the *Mandela Rules* requires reasonable accommodation and adjustments, which includes eliminating physical barriers for prisoners with mobility impairments, providing documents in Braille or as taped materials for prisoners with visual impairments and access to interpreters for prisoners with sensory disabilities. In the absence of a dedicated human rights instrument on older persons, reference is made to Article 2 of the CRPD, which defines "*reasonable accommodation*" as the "*necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms*". The European Court of Human Rights has also ruled that denial of accessible conditions and/or reasonable accommodation to older persons with disabilities while in custody amounts to inhuman or degrading treatment.[12]

27. In some systems, older prisoners are placed in separate, protected units, where the layout and settings corresponds to their individual requirements and where they can receive specialist care. In others, older prisoners are placed in the general prison, though sometimes in separate accommodation.[13]

28. For all prisoners, in particular older persons, to be able to access health-care services, careful consideration should be given to the setting and location of health-care facilities. Facilities should be easily accessible, particularly for older persons with physical disabilities.[14] Rule 109(2) of the *Mandela Rules* requires prison authorities to provide specialized facilities under the supervision of qualified health-care professionals for prisoners with cognitive disabilities and/or health conditions. Furthermore, "*any assessment or treatment should only be provided where the prisoner provides his or her informed consent*".[15]

29. Moreover, in assessing detention conditions, health-care staff should bear in mind Rules 12 to 23 of the *Mandela Rules*, all of which provide guidance on aspects of life in prison that can impact health, including accommodation, personal hygiene, clothing and bedding, food, exercise and sport. Rule 13, for instance, specifies that "*[a]ll accommodation provided for the use of prisoners and in particular all sleeping accommodation shall meet all requirements of*

[11] OSCE, Guidance Document on the Nelson Mandela Rules: Implementing the United Nations Revised Standard Minimum Rules for the Treatment of Prisoners, 2018, p. 70.
[12] See for example: *Price v. the United Kingdom*, Application no. 33394/96, 10 July 2001; *Vincent v. France*, Application no. 6253/03, 24 October 2006; *Grimailovs v. Latvia*, Application no. 6087/03, 25 June 2013; *Semikhvostov v. Russia*, Application no.8689.
[13] UNODC, Handbook on Prisoners with special needs Handbook, 2009, p. 127. 12,
[14] OSCE, Guidance Document on the Nelson Mandela Rules: Implementing the United Nations Revised Standard Minimum Rules for the Treatment of Prisoners, 2018, p. 150.
[15] OSCE, Guidance Document on the Nelson Mandela Rules: Implementing the United Nations Revised Standard Minimum Rules for the Treatment of Prisoners, 2018, p. 72.

health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation".[16]

V. State obligations regarding medical and psychological care for older persons deprived of liberty

30. Older prisoners may have accrued medical and psychological care requirements as a result of chronic and multiple health conditions, visual and hearing impairment or physical disabilities as well as neurodegenerative diseases like Alzheimer's disease. Health conditions are often exacerbated by stress and adverse effects of imprisonment itself, including depression and fear of dying in prison which negatively affect the well-being of older prisoners as well as unhealthy lifestyles, alcohol and substance abuse.[17]

31. Particular attention is required to ensure adequate health-care for older women in correctional facilities. While the focus on women's health in correctional settings is mostly on reproductive health of younger women, some inferences about the specific health-related requirements of incarcerated older women can be made from health-care requirements of older women in the community.[18] In the community, geriatric syndromes including cognitive impairment and dementia, incontinence, falls and functional impairment are more common in women than in men.[19] Osteoporosis, for instance, which increases the chance that a fall will lead to a fracture and to temporary or permanent disability, is four times as common in women over age 50 than men.[20]

32. State obligations regarding medical and psychological care for older persons deprived of liberty are embodied in the International Covenant on Economic, Social and Cultural Rights which affirms "*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*". In its General Comment No. 14 on the Right to the Highest Attainable Standard of Health[21] (para. 12 (b)), the Committee on Economic, Social and Cultural Rights specifies that health facilities have to be accessible to everyone without discrimination, within the jurisdiction of the State party and outlines the four overlapping dimensions of accessibility:

> Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds;
>
> Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying

[16] Ibid., p. 152.
[17] UNODC, Handbook on Prisoners with special needs Handbook, 2009, p.128.
[18] BJS, Prisoners in 2015, DoJ, OJP, Washington, DC, December 2016, available at: www.bjs.gov/content/pub/pdf/p15_sum.pdf.
[19] C. Seth Landefeld, Robert M. Palmer, Mary Anne Johnson, C. Bree Johnston and William L. Lyons, Current Geriatric Diagnosis and Treatment, McGraw-Hill, New York, 2004.
[20] Anne C. Looker, Lori G. Borrud, Bess Dawson-Hughhes, John A. Shepherd and Nicole C. Wright, "Osteoporosis or Low Bone Mass at the Femur Neck or Lumbar Spine in Older Adults: United States, 2005–2008", NCHS Data Brief, No. 93, National Center for Health Statistics, Hyattsville, MD, 2012.
[21] Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4).

> determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;
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> Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households;
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> Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

33. States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access including of prisoners or detainees.[22] With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Accordingly, the right to health includes "*preventive, curative and rehabilitative health treatment […] maintaining the functionality and autonomy of older persons […] attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity*".[23] Such measures should, consequentially, be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures.

34. Rule 24 of the *Mandela Rules* also affirms that "*[p]risoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.*"

35. The *Mandela Rules* provide specific guidance on how health-care services in prisons should be organized and the specific duties and responsibilities of health-care professionals. In addition, the Rules provide details on complying with the health care requirements of persons with cognitive or other health conditions. The Rules also reiterate the absolute prohibition of torture or other ill-treatment by health-care professionals and their obligation to document and report cases.

36. At the regional level, Article 3 of the European Convention on Human Rights imposes an obligation on Member States to protect the physical well-being of persons deprived of their liberty by, among other things, providing them with the requisite medical care.[24] Thus, the European Court of Human Rights has affirmed the right to standard of care for prisoners through its case law and has held on many occasions that lack of appropriate medical care may amount to treatment contrary to Article 3. In *Mouisel v. France*, for instance, the Court clarified that while Article 3 of the Convention does not create an obligation to release prisoners on grounds of health conditions, it creates an obligation to preserve the physical integrity of prisoners. This obligation includes providing adequate medical care. Where prisons cannot

[22] CESCR, General Comment 14, para. 34.
[23] See *Ibid*, para. 34 and 35.
[24] *Kudła v. Poland* [GC], 2000, § 94; *Paladi v. Moldova* [GC], 2009, § 71; *Blokhin v. Russia* [GC], 2016, § 136.

provide an acceptable level of care, States may have an obligation to transfer the prisoner to a facility that can provide proper treatment.[25] In *Hénaf v. France*, the Court reiterated that health, age and severe physical disability are among the factors to be taken into account under Article 3 of the Convention.[26]

37. In this context, the Court also affirmed that medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the State authorities have committed themselves to provide to the population as a whole.[27] However, the Court also explained that it reserved sufficient flexibility in defining the required standard of health care, deciding it on a case-by-case basis. That standard should be "*compatible with the human dignity*" of a detainee, but should also take into account "*the practical demands of imprisonment*".[28]

38. When the "*equivalence of care*" test is applied to the care of older persons in the correctional setting, it is important to use the field of geriatrics as the community benchmark for care. State obligations entail a duty to provide specialized geriatric care, as older persons have different patterns of disease presentation to younger adults and respond to treatments and therapies in different ways. They also frequently have complex social needs that are related to their chronic medical conditions and may contribute to their social exclusion.[29]

39. Geriatrics is the field of medicine that aims to adequately address the health, function, independence and quality of life of older patients through the lens of bio-psycho-social-cultural assessment and treatment. The field of geriatrics takes an older persons-centred approach to prioritizing and assessing the risks and benefits of different - and at times competing - interventions offered to patients with multiple medical conditions and impairments through a comprehensive assessment of their personal goals of care. To incorporate a geriatric health-care model in prison settings requires an understanding of the clinical conditions prioritized in geriatric care.

40. Gerontological social work, where it is provided, ensures a comprehensive approach to adapted care for older persons who require a range of age-specific services and who may, over a period of months, years, and sometimes decades, necessitate care at different levels. It also contributes to identifying barriers that may prevent or inhibit older persons from receiving required care.

41. In addition to chronic medical conditions, older persons frequently experience other "*geriatric syndromes*" that may have a negative impact on their physical function and quality of life. Examples include frequent falls, cognitive impairment and dementia, incontinence, sensory impairment and polypharmacy. The presence of geriatric syndromes such as these contributes to an older person's overall frailty and poor health outcomes. Older persons warrant a full geriatric evaluation upon intake at correctional facilities to identify whether any geriatric syndromes are present and, if so, to make recommendations for how to address these

[25] *Mouisel v. France*, Application No. 67263/01, 14 November 2002; see also see *Chartier v. Italy*, no. 9044/80, Commission's report of 8 December 1982, Decisions and Reports (DR) 33, p. 41; *De Varga-Hirsch v. France*, no. 9559/81, Commission decision of 9 May 1983, DR 33, p. 158; and *B. v. Germany*, no. 13047/87, Commission decision of 10 March 1988, DR 55, p. 271.

[26] *Hénaf v. France*, Application No. 65436/01, 27 November 2003; see also *McGlinchey and Others v. United Kingdom*, Judgment, Application No. 50390/99, 29 April 2003.

[27] *Blokhin v. Russia* [GC], 2016, para. 66.

[28] Ibid., para. 137; *Aleksanyan v. Russia*, 2008, para. 140; *Patranin v. Russia*, 2015, para. 69.

[29] A/HRC/39/50, para. 15.

conditions. Persons ageing in prisons should receive periodic reassessment (i.e. preferably annually) to identify and address new geriatric syndromes as they arise.[30]

42. Notwithstanding the heterogeneity of the group of older prisoners, they are likely to require a number of health care services on a regular basis, including medical, nutritional and psychological, and more frequent health monitoring. Moreover, in order to provide equivalence of care to the diverse group of older prisoners, prison health-care services must be adequately equipped and funded. Authorities must devote sufficient resources to ensure that prison health-care is adequate in relation to the size and requirements of the older prison population. Prison authorities need also to establish close cooperation with community health services, to ensure that specialist care is provided by outside medical services, as necessary, and that prisoners whose health care requirements cannot be met in prison are transferred to civilian hospitals without delay. Rule 27 of the *Mandela Rules* provides that "*[a]ll prisons shall ensure prompt access to medical attention in urgent cases. Prisoners who require specialized treatment or surgery shall be transferred to specialized institutions or to civil hospitals. Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide prisoners referred to them with appropriate treatment and care*."

43. In addition to the standards set out in the *Mandela Rules* for specialized care and treatment, the Revised European Prison Rules, in Rule 46, similarly affirm that:

> 46.1 Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals, when such treatment is not available in prison.
>
> 46.2 Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide the prisoners referred to them with appropriate care and treatment.

44. This rule requires the prison administration to ensure that it has, in addition to facilities for general medical, dental and psychiatric care, suitable arrangements in place to provide specialist consultation and in-patient care. This requires close cooperation between prison and community medical services to ensure that adequate arrangements are in place encompassing full spectrum of medical specialties. In planning for specialist, age-sensitive/adaptive care, particular attention should be given to the requirement of the most vulnerable segments of the prison population, such as older prisoners.

45. In addition to providing treatment to prisoners, prison administrations are responsible for ensuring that the conditions of imprisonment and daily life of prisoners do not adversely affect their wellbeing. Many prisoners are dependent on prison authorities for the provision of sanitation, good nutrition and drinking water, among other things, in order to maintain or improve their health, and require age-adapted and age-sensitive approaches. In assessing the detention conditions of prisoners in relation to their health, medical professionals should pay particular attention to the situation of prisoners with particular health-care requirements, including older prisoners and others with particular physical and cognitive health conditions.[31]

[30] IFRC, Ageing prisoners: An introduction to geriatric health-care challenges in correctional facilities, IFRC No. 903 December 2016.

[31] OSCE, Guidance Document on the Nelson Mandela Rules: Implementing the United Nations Revised Standard Minimum Rules for the Treatment of Prisoners, 2018, p. 152.

46. To adequately respond to health-care requirements in prisons, both, prison personnel and prison health-care providers may require specific training and education, including on geriatrics and gerontological social care. According to Rule 75 of the *Mandela Rules*, all prison personnel shall be provided with training tailored to their general and specific duties. This includes, as referred to in Rule 76(d) of the *Mandela Rules*, that all personnel receive training on the psychosocial needs of prisoners, social care and assistance, including early detection of cognitive health conditions. The requirement for prison personnel to receive specialist training, according to Rules 75 and 76 of the *Mandela Rules*, corresponds with the obligation of prison administrations to take account of the individual needs of prisoners, and "*to protect and promote the rights of prisoners with special needs*", as set out in Rule 2(2). If a staff member is transferred from one function to another they should be retrained accordingly.

47. Access to specialist facilities may often require the transfer of the prisoner to another location. Prison administrations will need to ensure that arrangements for escorting prisoners are suitable and do not lead to delays in treatment or additional anxiety for the prisoner. The conditions in which prisoners are transported should be appropriate to their medical condition.

48. While Article 3 of the European Convention on Human Rights does not establish a general obligation to release sick prisoners or place them in a civil hospital, it however provides for a States' onus to protect prisoners' physical well-being. In particularly serious health conditions, situations may arise where the proper administration of criminal justice requires remedies to be taken in the form of so-called "*humanitarian measures*", such as transfer to a civilian hospital or even release. The elements that the European Court of Human Rights takes into account in this context are: (1) the prisoner's condition; (2) the quality of care provided, and (3) whether or not the prisoner should continue to be detained in view of his or her state of health.[32] In connection to prolonged detention of older prisoners, particularly those with health conditions, the Court has noted that age in conjunction with other factors, such as health, may be taken into account either when the sentence is passed or while the sentence is being served.[33]

VI. Duties of the State in relation to palliative care of older persons

49. Particular attention needs to be given to palliative care. In certain countries, palliative care is not recognized as a medical specialty and the medicine used in such care is limited, for several reasons, including restrictive drug regulations, failure to implement a properly functioning supply and distribution system, and inadequate health-care system capacity.[34]

50. Palliative care is specialized medical care for persons with serious health conditions; its goal is to improve quality of life for the patient and their loved ones. Palliative care-trained clinicians have advanced training in symptom management and in the science of prognosis. Without training in prognosis, correctional clinicians may fail to identify potential candidates for early medical release programmes before it is too late for them to live through a prolonged assessment process.[35]

[32] Enea v. Italy [GC], No. 74912/01, 17 September 2009, paras 58-59.
[33] Papon v. France (no. 1) (dec.), No. 64666/01, 7 June 2001.
[34] A/HRC/30/43, para. 86; cf. Right to pain relief: 5.5 billion people have no access to treatment, warn UN experts World Hospice and Palliative Care Day of 9 October 2015 see https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16590&LangID=E .
[35] Ageing prisoners: An introduction to geriatric health-care challenges in correctional facilities, IRRC No. 903 December 2016, p. 933.

51. The Special Rapporteurs on the right to health and on torture and other cruel, inhuman or degrading treatment or punishment qualified the failure to ensure access to controlled medicines for the relief of pain and suffering as a threat to the fundamental right to health and the right to be free from cruel, inhuman and degrading treatment.[36]

52. Correctional settings present unique ethical and policy challenges in the provision of community-standard palliative care. For instance, there exists a great potential for patient-clinician mistrust due to the power imbalance inherent in the correctional setting.[37] The clinician-patient relationship may be strained further when patients fear that their treatment wishes will not be kept confidential or that their wishes for care at the very end of their life could affect their immediate needs for medical treatment.[38] An essential component of palliative care is patient-centered "*advance care planning*", a process by which a patient appoints a health-care proxy and documents his or her goals and wishes for treatment at the end of life.

53. Besides palliative care, another area of importance for older prisoners is hospice care that is focused on providing pain and symptom management – including managing existential and psychological distress – to patients in their last months of life. Quality hospice care provides comprehensive support that is focused on comforting and ensuring dignity in the dying process. Older persons need to have full and effective access to information about the types of treatment available at the end of their life so that their decisions are based on informed consent in line with human rights standards. There are correctional facilities that have developed hospice programmes or dedicated hospice facilities. It is important in this context that eligibility requirements in correctional facilities do not *de facto* constitute a barrier for older prisoners. Some prison hospice units require that a patient has a prognosis of less than six months and has agreed to a "*do not resuscitate order"*. The latter is not usually shared by community hospice organizations and can introduce an obstacle for individuals who do not wish to acquiesce to the order. It is important for correctional hospice programmes to follow national guidelines for good practices so that the level of care and services provided does not vary significantly by institution.

54. According to the World Health Organization, very often prisons are not equipped to provide palliative or hospice care, prison personnel lack the necessary training, education and resources. In addition, the prison environment itself is not conducive to end-of-life care. For this reason, many prison systems have introduced compassionate release programmes to allow terminally ill prisoners to be released from prison earlier in their sentence. Such early-release programmes fulfil a compassionate role but also recognize that the life expectancy of terminally ill prisoners may be lengthened as a result of receiving care in the community.[39]

55. The rationale of early medical release policies is that a change in health status may affect the four principles justifying incarceration: retribution, rehabilitation, deterrence and incapacitation.[40] Such policies generally have two stages, (i) medical eligibility, based on

[36] A/HRC/22/53.
[37] Meredith Stensland and Sara Sanders, "Detained and Dying: Ethical Issues Surrounding End-of-Life Care in Prison", Journal of Social Work in End-of-Life and Palliative Care, Vol. 12, No. 3, 2016.
[38] S. J. Loeb et al., "End-of-Life Care and Barriers for Female Inmates", Journal of Obstetric, Gynecologic, and Neonatal Nursing, Vol. 40, No. 4, 2011.
[39] WHO Europe, "Health in Prisons: A WHO Guide to the Essentials in Prison Health" (2007), 36.
[40] Brie A. Williams, Rebecca L. Sudore, Robert Greifinger and R. Sean Morrison, "Balancing Punishment and Compassion for Seriously Ill Prisoners", Annals of Internal Medicine, Vol. 155, No. 2, 2011.

physical health evidence; and (ii) administrative approval outside of the health-care system for release based on legal and correctional evidence.

56. Early release policies require a safe release plan to be identified. One important barrier to accessing early release is that applications are often submitted too late in a person's disease trajectory, when they are likely to die or become incapacitated prior to having their request approved. The common requirement for physicians to attest that the applicant has a fixed, short-term prognosis, puts an excessive burden on the clinician since many common terminal illnesses, such as Alzheimer's disease, end-stage liver disease and congestive heart failure, have an unpredictable trajectory but are profoundly incapacitating for many years prior to death. To increase their effectiveness, early medical release policies should reflect the different ways in which older persons experience serious illness. Patients should be able to apply for release at a stage in their illness when they are profoundly functionally or cognitively impaired, even when they have several months or years to live, so they can benefit from release.[41]

VII. Ensuring contact of older prisoners with their family

57. Feelings of isolation in the correctional setting can affect the mental health of older prisoners. The loss of family relations and the death of family and friends influence the well-being of older prisoners and their prospects of successful resettlement following release. Compared to younger prisoners, incarcerated older persons generally have fewer regular visitors and social relations within the prison as well as to self-help groups for example. This relative social isolation can lead to diminished functional capacity or may be exacerbated by it, putting older persons at a heightened risk for subsequent worsening loneliness and physical disability. Older female prisoners suffer particularly from separation from their families and communities, and especially in societies where the family, extended family and the local community are essential elements of the social fabric, in which women play the central role as caregivers.

58. Placing older prisoners as close as possible to home is important to help maintain contacts with family members. In addition, where resources allow, family visits can be organized, for those unable to travel. Regular prison leaves, enabling prisoners to spend time with their families and thereby to maintain contact with them, also comprise an effective way of keeping relationships alive and reducing the sense of isolation suffered by many older and long-term prisoners. In addition, prison authorities should encourage organizations of civil society which work with older persons to include prison visits and projects in prisons within their programmes. Consideration could be given to concluding agreements with such organizations to ensure that the contact is long term and sustainable.

VIII. State obligations regarding older persons' full social reinsertion

59. Individualized preparation for release programmes is of particular importance in the case of older prisoners. The existence or not of family relations and the length of imprisonment are two of the key factors determining prisoners' support requirements, to be addressed as part of pre-release preparation and post-release support programmes. For most older prisoners, but

[41] Brie A. Williams, "Testimony of Brie Williams, MD, MS", United States Sentencing Commission: Public Hearing on Compassionate Release and Conditions of Supervision, 17 February 2016, available at: www.ussc.gov/sites/default/files/pdf/amendment-process/public-hearings-and-meetings/20160217/williams.pdf.

especially for those who have grown old in prison, and for those who have no family to support them, helping re-establish relations with the community, including with health and welfare agencies, to ensure that their health care, housing and welfare needs are met on release, is particularly important. The prison service has to work in close coordination with probation services, where they exist, with relevant civil society actors to ensure that maximum possible support is provided to older prisoners during the difficult period of re-entry into society. Older women prisoners are likely to require special support and assistance.

60. The right to education is recognized by the *Mandela Rules*. There are reports of prison personnel bias against the participation of older prisoners in prisoner programs including as a result of misconceptions that older prisoners are not likely to progress.[42] It is essential to take into account that older persons learn differently from younger ones and have specific requirements and interests. Older persons learn to do, to know, to live together and to be, with informal learning playing an important role.[43]

61. Prisoner programmes are generally designed to cater for the needs of younger prisoners, aiming to reduce recidivism following release, by contributing to their professional skills and education, while older prisoners who passed the retirement age, may not be interested in vocational training courses.

62. Older prisoners have very specific requirements in terms of preparation for release. Ensuring access to age-appropriate education and training requires that the living environment (*Lebenswelt*) of older persons be taken into account in the planning and design of training and educational opportunities.[44] The needs will vary depending on the respective social, economic and health conditions, making individualized pre-release programmes particularly important for older prisoners. Anticipatory release planning should also address the continuation of care in the community. Upon release, States have the responsibility to ensure that older former prisoners have access to basic services, adequate health and care including long term care as well as an adequate standard of living.

IX. Conclusion

63. The Independent Expert on the enjoyment of all human rights by older persons emphasizes the imperative to adopt a human rights-based to older persons deprived of liberty. The principle of equality and non-discrimination not only results in the prohibition of different treatment when it is arbitrary, but also implies the obligation to establish differentiated measures when those are reasonable, necessary and proportional, precisely in order to guarantee the actual exercise of human rights. Such a differentiated approach to older persons deprived of liberty entails an obligation to take specific measures for older persons in prison to ensure that age-sensitive and -adapted detention conditions thereby enabling older prisoners to fully enjoy their human rights free from violations.

64. Older prisoners are to benefit from all the human rights guarantees on an equal footing with other prisoners. In the absence of a dedicated human rights instrument on older persons, required action in this connection can be inferred from the *Mandela Rules* and regional human rights instruments and jurisprudence, in particular the Inter-American Convention on

[42] UNODC, Handbook on Prisoners with special needs Handbook, 2009, p.125.
[43] A/HRC/30/43/Add.2, para. 42.
[44] *Ibid*., para. 44.

Protecting the Human Rights of Older Persons, to ensure that older persons in prison are treated in a manner which promotes and protects their rights, their sense of dignity and worth, facilitates their reintegration into society and takes their requirements into account.

Berlin, Wednesday, 4th of November 2020

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