Chapter 2
Ethics Within the Prison System

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Addressing ethical issues in prison psychiatry – on a global scale as well as in national perspectives and concerning special problems (see Part II) – goes along with a more general discussion of ethics in psychiatry and in the prison system. Focusing on psychiatric problems in prisons and with prisoners (rather than criminal law problems in psychiatry and with patients), ethical issues in the prison system are of major interest. Confronted with extreme ethical and professional conflicts there may be no way out than the way out of the system: Resigning rather than resignation, opposition rather than pragmatism. However, this chapter aims to highlight areas of good practice in prison psychiatry rather than further cultivate frontlines.

Beyond the question of ethics within the prison system the ethics of the prison (and its system) and of punishment in general arises: Although both perspectives cannot be separated without losing important insights, especially concerning the interactions between the structures of the penal justice system within the actual criminal policy framework and prison reality, this chapter will focus on immanent issues facing existing prisons throughout the world, rather than questioning their right to exist. On an academic scale, topics of the legitimacy of criminal law, punishment and incarceration may seem more 'exciting', not least from an ethical perspective (cf. Boonin 2008), but neither the prisoners nor professionals would benefit from this (see Sect. 2.1). At any rate, the Chap. 4 covers some of these issues. One of the main ethical dilemmas, not only in academic discussions, is – not in prison psychiatry alone, but in the whole prison system – the limit of scientific research: this issue will be mentioned, but the reader is also referred to the chapter "Ethics of research in prison psychiatry" in this volume. One of the 'solutions' to some

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of the ethical problems encountered in prison psychiatry might be the integration of prison health services into the general health service system, thus hoping those problems would not arise. Certainly ethical dilemmas should rather be avoided than setting up guidelines to handle them, but either way unavoidable ethical issues have to be solved.

The treatment of prison inmates is associated with a number of situations and conflicts raising ethical concern: "Excessive use of solitary confinement, lock-downs, unnecessary and humiliating strip, body cavity, and pat searches (sometimes exacerbated by being cross-gendered), long delays in processing calls for medical assistance, multiple celling, allowing prison conditions to become squalid, turning a blind eye to prisoner-on-prisoner abuse, chain-gang practices, and even institutional boredom, sometimes individually and often collectively violate ethical – even if not legal – demands that imprisonment not be cruel, inhuman, or degrading" (Kleinig 2008). Some of these problems will become more severe in the treatment of prisoners with mental disorders. Additional problems include: resource allocation, issues of patient choice and autonomy in an inherently coercive environment, the dual role of forensic psychiatrists giving raise to tension between patient care and protection of the public, the professional medical role of a psychiatrist and/or psychotherapist working in prison, the involvement of psychiatrists in disciplinary or coercive measures, consent to treatment, especially the right to refuse treatment or the use of coercion in forcing a prisoner to undergo treatment, hunger strike, confidentiality as well as the potential for high rates of decompensation and deterioration (Keppler et al. 2010). The high suicide rates among prisoners may be a marker of the inadequate or even inhumane treatment in prisons rather than an indication for the extent of mental disorders – or to put it differently: pathologizing these problems might become subject of ethical challenges.

Of course professionals within prison psychiatry (and in a certain sense even more so in prison psychology, see *Decaire* and *American Association for Correctional Psychology* 2010) not only face special ethical issues and challenges centered around mentally disordered prisoners but are also confronted with 'normal' prisoners and with the question of which prisoner is to be regarded mentally disordered (or not): This may be of advantage for the affected prisoner in terms of receiving adequate help on one hand; on the other hand, however, this may lead to further 'trouble' for him in terms of a psychiatric regime adding to the custody and correctional regime.

This chapter will discuss ethics within the prison system starting with short remarks on principles of the prison and its system (Sect. 2.1) followed by considerations on ethics in general (Sect. 2.2) and within the prison system in particular (Sect. 2.3). The main part will be formed by considerations of guidelines and recommendations devised as international (minimum) standards for the ethical treatment of prisoners in general (Sect. 2.4) and especially for the medical and psychiatric treatment (Sect. 2.5).

2.1 The Prison System

There is no uniform prison system. This is partly due to the variety of institutions that may be considered "prisons" in a broader sense, partly due to the classification of prisoners and the diversity within the prison as a system (see below).

The European "Prison Rules" (EPR), for example, "apply to persons who have been remanded in custody by a judicial authority or who have been deprived of their liberty following conviction. In principle, persons who have been remanded in custody by a judicial authority and persons who are deprived of their liberty following conviction should only be detained in prisons, that is, in institutions reserved for detainees of these two categories." But the Rules also apply to persons "who may be detained for any other reason in a prison; or who have been remanded in custody by a judicial authority or deprived of their liberty following conviction and who may, for any reason, be detained elsewhere" (10.1–3). Addressing "persons deprived of their liberty", the EPR speak of "prisons" as well as of "detention" and "custody". The standards of the European Committee for the Prevention of Torture (CPT-Standards 2009) refer to any place "where persons are deprived of their liberty by a public authority"; the CPT's mandate thus "extends beyond prisons and police stations to encompass, for example, psychiatric institutions, detention areas at military barracks, holding centres for asylum seekers or other categories of foreigners, and places in which young persons may be deprived of their liberty by judicial or administrative order". Furthermore, Art. 10 of the International Covenant on Civil and Political Rights (CCPR) applies "to anyone deprived of liberty under the laws and authority of the State who is held in prisons, hospitals - particularly psychiatric hospitals - detention camps or correctional institutions or elsewhere. States parties should ensure that the principle stipulated therein is observed in all institutions and establishments within their jurisdiction where persons are being held" (United Nations Human Rights Committee: General Comment [GC] 21, par. 2). As for this article "prison" is understood in the sense of the EPR.

Referring to the prison "system" draws attention to its place in the criminal justice system on the one hand and to the construction and organization of the prison as a system on the other hand (Zedner 2004). Within the criminal justice system the prison plays different roles: providing custody for pre-trial detention, incarceration for post-trial punishment, detention for post-punishment incapacitation or confinement for 'alternative' corrections. What they all have in common is the fact of imprisonment, being locked up involuntarily in a closed institution for an often extended period of time (as opposed to short term arrests in police stations, for example). This is true for other forms of detention, confinement, custody, etc. outside the criminal justice system as well, such as secure psychiatric hospitals, some homes for senior citizens or homes for juveniles. These institutions are therefore partly confronted with similar ethical challenges and the focus of committees for the prevention of torture, but nevertheless not the focus of this chapter. The prison as a system refers to differences in size, distinction, types of detention, treatment

and security, to questions of staffing, organization, bureaucracy or management as well as state vs. private facilities and authorities.

According to international rules, prisons shall be restricted to certain objectives: The penitentiary system shall comprise "treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation" (CCPR Art. 10 par. 3), which also means that "no penitentiary system should be only retributory; it should essentially seek the reformation and social rehabilitation of the prisoner" (GC 21 par. 10). In addition to the EPR that apply to all prisoners, the regime for sentenced prisoners shall be designed to enable them to lead a responsible and crime-free life: "Imprisonment is by the deprivation of liberty a punishment in itself and therefore the regime for sentenced prisoners shall not aggravate the suffering inherent in imprisonment" (EPR). Beyond the questions about why we legally punish people and for how long, however, there are many complex questions concerning how we should punish them: "We should structure prisons so that they afford inmates meaningful opportunities to live and act as responsible citizens, albeit citizens some of whose basic moral rights are legitimately and severely curtailed" (Lippke 2007).

We have to realize – in spite of all the well argued debates and even campaigns on abolition – that throughout most of the world the prison still is, and presumably will be for quite another while, not only the concrete symbol for at least the 'ultimate ratio' of criminal policies, but rather its 'backbone' (van Zyl-Smit and Dünkel 2001; Stern 2006). In societies where freedom is said to be the fundamental civil right, it is not surprising that detention is the fundamental punishment, not necessarily in terms of quantity but rather in terms of quality. Recently we have observed an overall increase in the rates of prisoners-per-population and a decrease in the rate of expenses-per-prisoner. At the same time expenses have been growing overall while budgets have been shrinking due to the described trends of relative mass imprisonment (van Zyl-Smit and Dünkel 2001; Downes 2001).

The traditional function of the prison, discipline and punishment through incarceration (Foucault 1995), was rationalized with ideas of correction and incapacitation (Zedner 2004; cf. Boonin 2008), but on a larger scale this does not make a difference: The role of the prison in the system of criminal policies seems to be more secure than ever – not anymore, however, only in terms of quality but more and more also in terms of quantity. Garland summed up what he called "the originating causes of mass imprisonment" as a result of the history of the closing decades of the 20th century: "anxieties about crime and violence; the demand for public protection; the notion that concern for victims excludes concern for offenders; political populism married to a distrust of the criminal justice system; the discrediting of social solutions to the problem of order; a stern disregard for the plight of the undeserving poor" (Garland 2001). However, the "perpetuating causes of mass imprisonment may be quite different", he continues – and in reference to Max Weber's work on "The protestant ethic and the spirit of capitalism" (from 1930) as well as his ideas on the "self-reproduction of institutions" identifies the outlines of a "new iron cage: It is quite possible that, given time, and the absence of concerted opposition, mass imprisonment will become a new 'iron cage' in Weber's sense of the term. … The most striking example of this is the emergence of a penal-industrial complex,

with newly vested interests in commercial prison contracts, and the jobs and profits they bring. … As the market in private security expands, the delivery of penal legislation speeds up, and the crime control culture reproduces itself, we face the real possibility of being locked into this state of affairs. After all, the new arrangements spawn institutional investments and produce definite benefits, particularly for the social groups who are at the greatest distance from them. They entail a way of allocating the costs of crime – unjust, unequal, but feasible nonetheless" (Garland 2001; Downes 2001; Sudbury 2004; McMahon 1997).

But these arrangements – "new economies" in the prison system (detailed in Pollähne 2010) – also involve serious social costs that will become increasingly apparent. These costs include, according to Garland (2001), "the allocation of state spending to imprisonment rather than education or social policy budgets; the reinforcement of criminogenic processes and the destruction of social capital, not just for inmates but for their families and neighbourhoods (Mahmood 2004); the transfer of prison culture out into the community; the discrediting of law and legal authority among the groups most affected; the hardening of social and racial divisions". These are indeed at least five good reasons to argue against the perpetuating of the prison system in general and mass-imprisonment specifically, even if the arguments are not really new, the abolitionists would claim (Davis 2003). But how to achieve such goals seems to be more uncertain than ever. Nevertheless the discourse on the emergence of a security industrial complex in general and a "penal" (Beckett 1997) or rather "prison industrial complex" in particular, has become a main topic in scientific debate (Davis 2003; Sudbury 2004; Mehigan and Rowe 2007; Wacquant 2008). And still: "As the criminal justice system grows, the size, resources, and authority of the interest groups that benefit from its expansion are also augmented. These beneficiaries – including law enforcement, correctional workers, and a growing number of private firms – constitute what has become to be known as the 'penal-industrial complex' and are now mobilizing to ensure that the wars on crime and drugs continue" (Beckett 1997; Stern 2006; Sudbury 2004).

Prisons need to be understood as serving many functions, some of which are more obvious than others: "We need to describe the reality of the prison against the backcloth of contemporary sensibility. But these ideas about punishment and its purpose, and penal values, influence practice and constitute penal sensibility" (Liebling and Arnold 2004; Zedner 2004). In what way is the "carceral texture of society" related to the daily texture of the prison? Can prisons ever be anything other than places of punishment? (Zedner 2004, Christie 2000; on "punitivity" Kury and Ferdinand 2008; about "ethical dilemmas in the medical model", Sissons 1976).

It is hard to be optimistic about the future of prisons: "Given their infamous track records, it would be easier to call for their abolition than reform. Yet as a practical matter, it is exceedingly unlikely that prisons are going to disappear any time soon. Besides, there are theoretical reasons for believing that we should retain them. We would do better, it seems to me, to rethink what we want them to do and how. It seems clear that we cannot continue to structure them so that they are deeply hostile to the nurture and exercise of those skills and dispositions constitutive of responsible citizenship. Many who enter prisons from less than reasonably just societies have

weak capacities for responsible citizenship to begin with. It is simply implausible to believe that subjecting such individuals to harsh and restrictive conditions will strengthen those capacities. Indeed, it is far more likely that such conditions will erode the relevant capacities and convince many offenders that they have little to gain from law-abiding conduct" (Lippke 2007).

2.2 Ethics

Ethics may be understood as "the moral principles governing or influencing conduct" (see the glossary in Kallert and Torres-Gonzáles 2006) – as if it was that simple to equalize ethics and morals. However, ethical guidelines for conduct are also not the same as lawful obedience: Obeying relevant laws – relevant especially in terms of the treatment of prisoners – should be regarded as one of the minimum ethical requirements; however, this does not mean that following lawful rules will fulfill these requirements and, even worse, might turn out unethical nonetheless. On the other hand, 'obeying' ethical guidelines may, in exceptional circumstances, lead to breaking the law, but will – in most cases – not serve as a legal justification.

Ethics is concerned with the study of "questions of right and wrong … good or bad" in terms of "moral judgments we assign to actions and conduct" (Banks 2009). Addressing actions and conduct "within" the prison system we may skip over metaethics and focus on normative ethics on one hand, concerned with "ways of behaving and standards of conduct", and applied ethics on the other hand, solving "practical moral problems as they arise, particularly in the professions, such as medicine and law". Both perspectives provide us with "a way to make moral choices when we are uncertain about what to do in a situation involving moral issues. In the process of everyday life, moral rules are desirable, not because they express absolute truth, but because they are generally reliable guides for moral circumstances" (ibid). We need a system of rules and principles to help guide us in making difficult decisions when moral issues arise: "If we cannot draw upon an ethical framework, we have to rely on emotion, instinct, and personal values, and these cannot supply an adequate answer to moral dilemmas"; and only through studying ethics is it "possible to define unethical behavior. A full understanding of ethical behavior demonstrates that it includes not only 'bad' or 'evil', but also inaction that allows 'bad' or 'evil' to occur" (Banks 2009).

Ethical systems provide "guidelines or a framework to which one can refer to in the effort to make a moral decision" (Pollock and Becker 1995). A discussion of ethical systems also demonstrates "that often there is more than one 'correct' resolution to a dilemma and more than one way to arrive at the same resolution" (Pollock and Becker 1995); such systems can be identified as religious ethics (what is good conforms to a deity's will), natural law (what is good is what conforms to true human nature), ethical formalism (what is good is what is pure in motive), utilitarianism (what is good is what results in the greatest good for the greatest number) and the ethics of care (what is good is that which meets the needs of those involved and doesn't hurt relationships, etc.). What is needed is a set of principles to which we

aspire in law and in contemporary moral and political philosophy, first virtues, the foundation of our social life, and also virtues that human beings need (Liebling and Arnold 2004).

Focusing on the prison system as part of the justice system and the professionals within these systems, ethics is inevitably high up on the agenda, for the criminal justice system "comprises professionals who exercise power and authority over others and who in some cases are authorized to use force and physical coercion against them" (Banks 2009). The laws as well as other accepted standards of behavior impose ethical rules and responsibilities on these professionals, who must be "aware of ethical standards in carrying out their functions. Ethics is crucial in decisions involving discretion, force, and due process, because criminal justice professionals can be tempted to abuse their powers" (Banks 2009) – in short: "Studying and applying ethics is a prerequisite for any competent criminal justice professional" (Banks 2009). And this is even more so true for professionals in the prison system, no matter if their profession is law or medicine, corrections or psychiatry, management or psychology. "Relations where strong power differences exist, where conflicts of interest are likely, or where decisions are made in uncertain situations are all areas where particular attention to ethics is needed" (Banks 2009).

Law enforcement ethics is particularly germane for a number of issues "relevant to police, the discretionary nature of policing, the authority of police, that fact that they are not 'habitually moral', the crisis situations, the temptations, and peer pressure" (Pollock and Becker 1995) such as "gratuities, corruption, bribery, 'shopping', whistle-blowing and loyalty, undercover tactics, use of deception, discretion, sleeping, sex on duty and other misfeasance, deadly force, and brutality" (Pollock and Becker 1995). Officers' codes of ethics know five common elements: "legality (enforcing and upholding the laws), service (protecting and serving the public), honesty and integrity, loyalty, and some version of the Golden Rule, or respect for other persons" (Pollock and Becker 1995). Good relationships between staff and prisoners may increase the chances of compliance with penal regimes, but they cannot guarantee it: "the sources of validity of value systems must be that they are 'good' and 'right' according to general conceptions of 'what humans should try to achieve or preserve in their lives as a whole'. Values and general principles need something other than instrumental justification or sources of authority. Consequentialism is not enough." (Liebling and Arnold 2004).

To return to the knotty relationship between ethics and law, we have to realize they are distinct. By law we generally mean "legislation, statutes, and regulations made by states and by the federal government on a host of subjects for the public good and public welfare" not intended to incorporate ethical principles or values, but sometimes – at least – "ethical standards will be reflected in laws" (Banks 2009). Legislation regulating the legal profession or other professions may give legal effect to certain professional codes of conduct, but ethical standards are not necessarily written down in form of laws or other rules. However, they should represent the collective experience of a society as they regulate the behavior of those who make up that society: "The fact that an ethical standard is not repeated or copied in a law does not affect the validity of that ethical standard" (Banks 2009) and sometimes, as mentioned earlier, laws can conflict with ethical standards, in a collective as well as

in an individual perspective – civil disobedience may be one answer to this key ethical dilemma (Banks 2009). Somewhere in this triangle of morals, laws and ethics we will find the guidelines for conduct and the principles for the treatment of others – i.e.: prisoners. Discussing ethics within a social (sub-)system – i.e.: the prison – has to consider the practical philosophy of institutional philosophies as well as individual conduct.

2.3 Ethics Within the Prison System

"The degree of civilization in a society is revealed by entering its prisons" (Dostojewski 1860). Addressing ethics within the prison system we face ethical dilemmas and issues. The latter usually comprise issues of "public policy involving ethical questions" (see the summary in Banks 2009 and the material in Schmalleger and Smylka 2008), whereas an ethical dilemma is "the responsibility of an individual" and requires a decision to be made that involves "a conflict at the personal, interpersonal, institutional, or social level or raises issues of rights or moral character" (Banks 2009). Since there are many gray areas where there are no specific rules, laws, or guidelines laid out in advance, it is "not always easy to know which decision is the most ethical choice" (Banks 2009). To rely on or refer to "natural law" that represents "a search for moral absolutes that define what is 'normal' and 'natural'", may seem anachronistic, but nowadays, natural law arguments "have tended to gravitate towards arguments in favor of human rights" (Banks 2009).

From here on it does make sense to refer to international human rights standards, not merely in terms of "hard law" (conventions, covenants, treaties …), which should of course be obeyed, but especially in terms of the so called "soft law" (recommendations, standards, guidelines, etc.) issued by international renowned political (United Nations – UN; Council of Europe – CoE) and professional institutions (i.e. the World Medical Association – WMA). Returning to the categories of normative vs. applied ethics we should focus on standards for conduct on the one side and solutions for practical professional problems on the other. Addressing ethics within the prison system – and also "in correction" (Banks 2009) – means to outline standards for "guarding ethically" (Banks 2009). Arguing that "if offenders are to become responsible citizens, it was essential that they were treated in a civil manner by correctional authorities, whose task was to model good citizenship by protecting certain fundamental rights" (former commissioner of corrections in Massachusetts, Vose; Banks 2009), still holds true – unless we were not longer aiming for offenders and especially prisoners to become "responsible citizens". This would, however, constitute radical social exclusion, incompatible with international human rights standards: "Treatment that is intended to degrade or dehumanize inmates is not authorized by the sanctions society has imposed on them" (Kleinig 2001 and Banks 2009) or rather: may not be authorized by any society without following unethical paths. More recently, however, human rights activists "have shown how brutalizing and degrading practices continue to exist in the prison system";

similarly it has been claimed that "anything posing as a correctional ethics is a nonsense" and that the operation of a humane correctional system "is rendered almost impossible" (Banks 2009). Perhaps "far too much debate is centered on the humanity of what goes on in prisons as a substitute for thinking about why prisons as a social institution should continue to exist" (O'Connor 2006).

What is problematic about "cruel and unusual punishment" is that it is inhuman and degrading, because it displays "a failure of regard for one of the basic requirements for human interaction: A basic moral requirement for our interaction with others is a recognition of their oneness with ourselves as feeling, perceiving, and reasoning beings, and giving their feelings, perceptions, and reasons the same weight that we give our own" (Kleinig 2008). Human dignity has its foundations in our capacity to frame for ourselves the choices we make, the paths we tread, and the goals we pursue: "To 'carry oneself with dignity' is not simply to have a particular standing but also to assert control over the terms of one's self-presentation. The danger of imprisonment is that it will diminish both control and self-representation. It becomes an engine of degradation" (Kleinig 2008).

The notion that a guard's authority over inmates can become corrupted is well established in correctional studies and is frequently referred to as a category of ethical misconduct: "In essence, 'corruption of authority' refers to a practice by guards of deliberately refraining from enforcing prison rules and regulations" (Banks 2009); they operate as agents of social control with a role ambiguity as "a result of having to perform both treatment and custodial roles" (Banks 2009). The most obvious fact about the prison environment is that guards are vested with power and authority over the prisoners and exercise that power to control them in accordance with prison rules and regulations: "It is the exercise of this power that creates ethical issues and dilemmas" (Banks 2009; Goffman 1968; Zedner 2004).

When staff respect prisoners, "they unlock them on time, they respond to calls for assistance, and they try to solve problems. Staff are more likely to take this approach when they feel treated with respect themselves"; being treated disrespectfully or without dignity generates negative emotions (anger, tension, indignation, depression, and rage; Liebling and Arnold 2004). Although guards' discretionary powers have been curtailed over time, they nevertheless continue to exercise "significant discretion in carrying out their day-to-day tasks. Discretionary power can easily involve questions of ethical conduct, and some argue it is preferable to limit discretion even more by expanding the written rules and regulations of the prison" (Banks 2009). But discretion should be allowed "whenever there is an absence of policy or where the policy is vague or inconsistent, on the basis that full enforcement of prison rules, policies, and procedures is an impossibility. The discretionary power of guards is shaped less by formal rules than by 'an explicit understanding of the shared operational values and ethical principles that govern correctional practice'" (Banks 2009 referring to Pollock 2004).

Under what conditions should prisoners be kept? First off, Kleinig answers, "we need to remind ourselves that people are sent to prison as punishment and not for punishment. Conditions need not be easy, but neither should they be unduly harsh" (Kleinig 2008; Zedner 2004). The doctrine of 'penal austerity' gets what

plausibility it has from the idea that punishment is to be seen as an imposition, not a benefit: "But the imposition is constituted by the confinement. More significantly, because the choice to imprison gives the state almost total control over the conditions of a person's life, the state also acquires the obligation to ensure that those conditions are acceptable and do not humiliate or degrade" (Zedner 2004; Goffman 1968). When the state incarcerates it assumes responsibility for the care of inmates: "First and foremost, that involves both a recognition of and a commitment to the preservation of their dignity", which should not be compromised during the period of incarceration, but should be reflected "in care for prisoners' physical and psychic well-being as well as concern for their better flourishing in future" (Goffman 1968). How material goods are delivered, how staff approach prisoners, how managers treat staff, and how life is lived, through conversation, encounter, or transaction, "constitute (above minimum threshold) key dimensions of prison life; these are the things that matter'" (Liebling and Arnold 2004). "We have used the term 'moral performance' in order to make our case that the prison is a moral place, and that prisons differ in their moral practices" (Liebling and Arnold 2004).

The ethical issue most commonly raised in relation to the provision of medical services to the inmate is "the question of interference with the prisoner's right to treatment, no matter what his offence" (Sissons 1976). The root cause of poor medical treatment in the prison is not solely a result of deliberate misuse or the withholding of adequate services, it is often the result of a difficult question of priorities: "The competitive situation of medical services within the prison system is rendered ambiguous, however, by the fundamental confusion which exists between the provision of medical care for an inmate who is suffering from a physical complaint and the function of medicine in relation to the criminal when crime is identified as individual pathology" (Sissons 1976). But "prison health is public health" (Keppler et al. 2010). The "principle of equivalence" demands: Prisoners should have access to the same standard of treatment as patients in the community in terms of justice for the vulnerable who should not be subjected to additional punishment through deprivation from healthcare (Pont in Keppler and Stöver 2010). The opposite would be "deliberate indifference" to a prisoner's health which may constitute "cruel and unusual punishment", prohibited by, e.g., the Eighth Amendment of the United States Constitution (see UTMB Institute for Medical Humanities 2007). There is a significant empirical link between aspects of "a prison's moral performance and (a) levels of psychological distress, anxiety, and depression found amongst prisoners; and (b) its suicide rate"; poor treatment leads to negative emotions - it is distressing and damaging for individuals (Liebling and Arnold 2004).

2.4 International Minimum Prison Standards

International covenants are binding upon the state parties due to the fundamental international principle of 'pacta sunt servanda', according to which treaties must be abided by: "Nevertheless, individual claims can usually not be made in reference to

regulations contained in international treaties, since the individual is not normally a subject of public international law" (Conrady/Roeder in Kallert/Torres-Gonzáles 2006). Individuals are dependent on the implementation of the international rules by their national governments, i.e. the incorporation of international rules in national law: "This process of implementation and, more generally, the way state parties abide by the treaties they conclude, are being monitored by certain organs related to the respective treaty" (Kallert and Torres-Gonzáles 2006 and Pollähne 2007 about the Committee for the Prevention of Torture - CPT). Beyond the implementation of international "hard law" (i.e. human rights covenants) in state parties' practices (as a 'top down'-process), the "soft law" instruments (see below) are more likely to determine individual ethical-professional conduct (as a 'bottom up'-attempt and in search for "best practice").

2.4.1 Principles

Above all the Universal Declaration of Human Rights (1948), art. 2: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment" (confirmed in the CCPR art. 7) has to be mentioned. All persons deprived of their liberty "shall be treated with humanity and with respect for the inherent dignity of the human person" (CCPR art. 10 par. 1). Although this right is not separately mentioned in the list of non-derogable rights in art. 4 par. 2 regarding "the peremptory nature of some fundamental rights", the UN-Human Rights Committee believes "that here the Covenant expresses a norm of general international law not subject to derogation" (GC 29 par. 13).

The EPR (2006) list the following Basic Principles:

1. All persons deprived of their liberty shall be treated with respect for their human rights.
2. Persons deprived of their liberty retain all rights that are not lawfully taken away by … sentencing them or remanding them in custody.
3. Restrictions placed on persons deprived of their liberty shall be the minimum necessary and proportionate to the legitimate objective for which they are imposed.
4. Prison conditions that infringe prisoners' human rights are not justified by lack of resources.
5. Life in prison shall approximate as closely as possible the positive aspects of life in the community.
6. All detention shall be managed so as to facilitate the reintegration into free society of persons who have been deprived of their liberty.
8. Prison staff carry out an important public service and their recruitment, training and conditions of work shall enable them to maintain high standards in their care of prisoners.
9. All prisons shall be subject to regular government inspection and independent monitoring.

2.4.2 Prohibition of Torture

The prohibition of torture (in the stricter sense) should not have to be mentioned when talking about the prison system for it may seem to be merely a question of criminal procedures and police interrogations. However "education and information regarding the prohibition against torture" should be "fully included in the training of law enforcement personnel (…), medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment" (UN Convention Against Torture – CAT art. 10).

In their "Resolution on Prohibition of Physician Participation in Torture" the WMA-Council reaffirmed (Tel Aviv 2009) its Declaration of Tokyo "Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment" (2006) in relation to detention and imprisonment, which prohibits physicians from participating in, or even being present during, the practice of torture or other forms of cruel, inhuman or degrading procedures, and urges National Medical Associations to inform physicians and governments of the Declaration and its contents. The WMA also reaffirmed its Declaration of Hamburg (1997) "Support for Medical Doctors Refusing to Participate in or to Condone the use of Torture or other Forms of Cruel, Inhuman or Degrading Treatment" and also its resolution "Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of which they are Aware" (2007), and urged national medical associations to speak out in support of this fundamental principle of medical ethics and to investigate any breach of these principles by association members of which they are aware. In the "Madrid Declaration on Ethical Standards for Psychiatric Practice" (2005) the WPA added that psychiatrists shall not take part "in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts".

The Tokyo-Declaration emphasized that it is "the privilege of the physician to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity" (preamble). Physicians shall not "provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment"; shall not be present "during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened", and must have "complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible", for his/her "fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose" (par. 2, 4 and 5; cf. *Morgan and Evans* 2003).

The WMA "Responsibility"-Resolution (2007) recognizes that "careful and consistent documentation and denunciation by physicians of cases of torture and of

those responsible contributes to the protection of the physical and mental integrity of victims and in a general way to the struggle against a major affront to human dignity" (par. 16) and that "the absence of documenting and denouncing acts of torture may be considered as a form of tolerance thereof and of non-assistance to the victims" (par. 19). Recommended is the "ethical obligation on physicians to report or denounce acts of torture or cruel, inhuman or degrading treatment of which they are aware; depending on the circumstances, the report or denunciation would be addressed to medical, legal, national or international authorities, to non-governmental organizations or to the International Criminal Court", and an "ethical and legislative exception to professional confidentiality that allows the physician to report abuses, where possible with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent" (rec. 9 par. 1 and 2, referring to par. 68 of the UN-Istanbul Protocol "Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment", 1999; Frewer and Furtmayr 2007).

2.4.3 Inhuman or Degrading Treatment or Punishment

Inhuman or degrading treatment or punishment is mentioned in one breath with the prohibition of torture, and "does not include pain or suffering [however] arising only from, inherent in or incidental to lawful sanctions" (CAT art. 1 par. 1). At any rate the state parties have to prevent "other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture", when such acts are "committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity" (CAT art. 16 par. 1).

CCPR art. 10 contains "a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty"; they may not be "subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the Covenant, subject to the restrictions that are unavoidable in a closed environment" (GC 21 par. 3). This is a fundamental and universally applicable rule. Consequently, the application of this rule, as a minimum, cannot be "dependent on the material resources available in the State party. This rule must be applied without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (GC 21 par. 4).

"Good order" in prison shall be maintained by taking into account "the requirements of security, safety and discipline, while also providing prisoners with living conditions which respect human dignity" (EPR 49). Disciplinary procedures should be mechanisms of last resort: "Whenever possible, prison authorities shall use mechanisms of restoration and mediation to resolve disputes with and among prisoners"; only conduct "likely to constitute a threat to good order, safety or security may be defined as a disciplinary offence" (EPR 56 and 57.1).

"Collective punishments and corporal punishment, punishment by placing in a dark cell, and all other forms of inhuman or degrading punishment" is prohibited; solitary confinement shall be imposed as a punishment "only in exceptional cases and for a specified period of time, which shall be as short as possible", and instruments of restraint shall never be applied as a punishment (EPR 60.3–6). Prison staff shall not use force against prisoners "except in self-defence or in cases of attempted escape or active or passive physical resistance to a lawful order and always as a last resort", whereas the amount of force used shall be "the minimum necessary and shall be imposed for the shortest necessary time"; staff who deal directly with prisoners shall be trained in "techniques that enable the minimal use of force in the restraint of prisoners who are aggressive" (EPR 64 and 66).

The CPT-Standards (2009) have so far and by far provided the most precise and detailed guidelines for the prevention of inhuman or degrading treatment or punishment (Pollähne 2007) in prisons as well as in psychiatric institutions. It would go far beyond the scope of this chapter to name but a few relevant standards: a thorough study is recommended!

2.4.4 Prisoner Status/Prisoners' Rights

The "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world" (CCPR preamble); each state has "to ensure to all individuals within its territory and subject to its jurisdiction the rights" recognized in the CCPR, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (CCPR art. 2 par. 1; similar the European Convention for the Protection of Human Rights and Fundamental Freedoms – ECHR art. 1). "Everyone" has the right to respect for his private and family life, his home and his correspondence (ECHR art 8 par. 1), and there shall be no interference by a public authority with the exercise of this right "except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others" (ECHR art 8 par. 2). Addressing "all" members or individuals and the rights of "everyone" has to be understood as fully including prisoners as a rule with the necessity of justifying exclusions.

No public authorities and institutions, national or local, shall "engage in any practice of racial discrimination." (UN Convention on the Elimination of all Forms of Racial Discrimination – CERD-Committee, General Recommendation 13 par. 1). The fulfilment of this obligation very much depends upon "national law enforcement officials who exercise police powers, especially the powers of detention or arrest"; they should receive "intensive training to ensure that in the performance of their duties they respect as well as protect human dignity and maintain and uphold the

human rights of all persons without distinction as to race, colour or national or ethnic origin" (UN Convention on the Elimination of all Forms of Racial Discrimination – CERD-Committee, General Recommendation 13 par. 2).

2.4.5 Staff and Management

Prisons shall be managed within an ethical context which recognises the obligation to treat all prisoners with humanity and with respect for the inherent dignity of a human person: "Staff shall manifest a clear sense of purpose of the prison system. Management shall provide leadership on how the purpose shall best be achieved. The duties of staff go beyond those required of mere guards and shall take account of the need to facilitate the reintegration of prisoners into society after their sentence has been completed through a programme of positive care and assistance"; at all times staff shall "conduct themselves and perform their duties in such a manner as to influence the prisoners by good example and to command their respect" (EPR 72 and 75). When selecting new staff the prison authorities shall place great emphasis on "the need for integrity, humanity, professional capacity and personal suitability for the complex work that they will be required to do" (EPR 77 and 78). The training of all staff shall include "instruction in the international and regional human rights instruments and standards" (EPR 81.4; cf. the CPT-standards 2009 chapter VIII and Pollähne 2010).

2.5 Ethical Standards for Prison Health and Psychiatry

Before addressing relevant ethical principles and human rights standards concerning prison health some general health recommendations and patients' rights should be recalled (cf. Alfredsson and Tomaševski 1998).

2.5.1 General Health Aspects

It is "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN Covenant on Economic, Social and Cultural Rights – CESCR art. 12 par. 1). Health is "a fundamental human right indispensable for the exercise of other human rights"; everyone can claim health rights "conducive to living a life in dignity" (CESCR-Committee GC 14 par. 1). The right to health is closely related to and dependent upon the realization of other human rights, including "the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information …" which address integral components of the right to health (CESCR- Committee GC par. 3).

The right to health in all its forms and at all levels contains the following interrelated and essential elements: (a) *availability;* (b) *accessibility*: Health facilities, goods and services have to be accessible to everyone without discrimination [in] four overlapping dimensions: (i) 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, (ii) physical accessibility, (iii) economic accessibility (affordability) and (iv) information accessibility; (c) *acceptability*: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned; (d) *quality*" (GC 14 par. 12). In particular, CESCR States parties are under an obligation to respect the right to health by, inter alia, refraining from denying or limiting "equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services"; furthermore to refrain from "marketing unsafe drugs and from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases", which should be subject to specific and restrictive conditions, respecting best practices and applicable international standards (GC 14 par. 34).

The CoE-Convention "For the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine" (Oviedo-Convention on Human Rights and Biomedicine 1997) emphasizes "consent". An intervention in the health field may only be carried out after the person concerned has given "free and informed consent" to it on the basis of "appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks"; the person concerned may freely withdraw consent at any time (art. 5). An intervention may also be carried out on a person who does not have the capacity to consent, "for his or her direct benefit": Where, according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons, the intervention may only be carried out "with the authorisation of his or her representative or an authority or a person or body provided for by law", the individual concerned shall as far as possible "take part in the authorisation procedure" (ibid art. 6 par. 1 and 3).

The European Charter of Patients' Rights (2002) aims "to guarantee a high level of human health protection and to assure the high quality of services provided by national health services in Europe" and comprises the rights of every individual to (1) preventive measures, i.e. appropriate services to prevent illness; (2) access to the health services that his or her health needs require meaning "equal access to everyone, without discriminating on the basis of financial resources, place of residence, kind of illness or time of access to services"; (3) access to all kinds of information regarding their state of health, the health services and how to use them; (4) access to all information that might enable him or her to actively participate in the decisions regarding his or her health; this information is a prerequisite for any procedure and

treatment, including the participation in scientific research; (5) freely choose from among different treatment procedures and providers on the basis of adequate information; (6) confidentiality of personal information, including information regarding his or her state of health and potential diagnostic or therapeutic procedures, as well as the protection of his or her privacy during the performance of diagnostic tests, specialist visits, and medical/surgical treatments in general; (7) swiftly receive necessary treatment within a predetermined period of time – this right applies at each phase of the treatment; (8) access to high quality health services on the basis of the specification and observance of standards; (9) to be free from harm caused by the poor functioning of health services, medical malpractice and errors, and the right of access to health services and treatments that meet high safety standards; (10) access to innovative procedures, including diagnostic procedures, according to international standards and independent of economic or financial considerations; (11) to avoid as much suffering and pain as possible, in each phase of his or her illness; (12) diagnostic or therapeutic programmes tailored as much as possible to his or her personal needs; (13) to complain whenever he or she has suffered a harm and the right to receive a response or other feedback; (14) to receive sufficient compensation within a reasonably short time whenever he or she has suffered physical, moral or psychological harm caused by a health service intervention.

The WMA set up an "International Code of Medical Ethics" (rev 2006) with the following general "duties of a Physician": to always "exercise his/her independent professional judgment and maintain the highest standards of professional conduct"; respect a competent patient's "right to accept or refuse treatment"; be dedicated to "providing competent medical service in full professional and moral independence, with compassion and respect for human dignity"; deal honestly with patients and colleagues, and report to the appropriate authorities those physicians "who practice unethically or incompetently or who engage in fraud or deception"; respect the rights and preferences of patients, colleagues, and other health professionals; certify only that which he/she has "personally verified"; strive to use health care resources "in the best way to benefit patients and their community" and – of course – "respect the local and national codes of ethics". Concerning his "duties to patients" a physician shall "always bear in mind the obligation to respect human life; act in the patient's best interest when providing medical care; owe his/her patients complete loyalty and all the scientific resources available to him/her"; respect a patient's "right to confidentiality"; in situations when he/she is acting for a third party, ensure "that the patient has full knowledge of that situation; not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship". From the "Declaration of Geneva" (2006) is to be mentioned the "pledge to consecrate my life to the service of humanity: I will practise my profession with conscience and dignity; the health of my patient will be my first consideration; I will respect the secrets that are confided in me, even after the patient has died; I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; I will not use my medical knowledge to violate human rights and civil liberties, even under threat".

The WMA Declaration of Madrid (2009) also emphasizes the importance of professional autonomy calling for "the assurance that individual physicians have the freedom to exercise their professional judgement in the care and treatment of their patients" (art. 1), and reaffirming the importance of professional autonomy as an "essential component of high quality medical care and therefore a benefit to the patient that must be preserved" as an essential principle of medical ethics (art. 2).

It goes without saying that these principles also have to be applied to the health system within the prison system and to the role of physicians in this system.

2.5.2 Prison Health

Prison authorities shall safeguard the health of all prisoners in their care: "Medical services in prison shall be organised in close relation with the general health administration of the community or nation. Health policy in prisons shall be integrated into, and compatible with, national health policy. Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation. Medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer. All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose" (EPR 39 and 40).

When examining a prisoner particular attention should be paid to: "a. observing the normal rules of medical confidentiality; b. diagnosing physical or mental illness and taking all measures necessary for its treatment and for the continuation of existing medical treatment; c. recording and reporting to the relevant authorities any sign or indication that prisoners may have been treated violently; d. dealing with withdrawal symptoms resulting from use of drugs, medication or alcohol; e. identifying any psychological or other stress brought on by the fact of deprivation of liberty; f. isolating prisoners suspected of infectious or contagious conditions for the period of infection and providing them with proper treatment; g. ensuring that prisoners carrying the HIV virus are not isolated for that reason alone; h. noting physical or mental defects that might impede resettlement after release; i. determining the fitness of each prisoner to work and to exercise; and j. making arrangements with community agencies for the continuation of any necessary medical and psychiatric treatment after release, if prisoners give their consent to such arrangements" (EPR 42.3).

Medical practitioners shall "have the care of the physical and mental health of the prisoners and shall see, under the conditions and with a frequency consistent with health care standards in the community, all sick prisoners, all who report illness or injury and any prisoner to whom attention is specially directed; (…) pay particular attention to the health of prisoners held under conditions of solitary confinement, shall visit such prisoners daily, and shall provide them with prompt medical assistance and treatment at the request of such prisoners or the prison staff and (…) report to the director whenever it is considered that a prisoner's

physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement" (EPR 43).

Of special importance the "WMA Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases" (2000) notes: Prisoners have the right to "humane treatment and appropriate medical care" referring to several UN-Standards for the treatment of prisoners (art. 1). The relationship between physician and prisoner is governed by "the same ethical principles as that between the physician and any other patient" (art. 2). Careful attention shall be paid to "protecting the rights of prisoners, regardless of their infected status, and according to the various UN instruments relating to conditions of imprisonment" (art. 7 par.1); the conditions in which detainees and prisoners are kept, whether they are held during the investigation of a crime, whilst awaiting trial, or after sentencing, shall "not contribute to the development, worsening or transmission of disease" and prisoners shall not be "isolated or placed in solitary confinement, without adequate access to health care and all appropriate responses to their infected status" (par. 2). Physicians working in prisons have "the duty to report to the health authorities and professional organisations of their country any deficiency in health care provided to the inmates and any situation involving high epidemiological risk for them" (art. 8).

In "Nurses' role in the care of detainees and prisoners" the International Council of Nurses (ICN, Position 2005) has noted that prisoners have "the right to health care and humane treatment: We condemn interrogation procedures and any act or behaviour harmful to mental and physical health". Prisoners also have the right "to clear and sufficient information; to refuse treatment or diagnostic procedures; and to die with dignity and in a peaceful manner". Nurses' primary responsibility is to those people who require nursing care: "In caring for detainees and prisoners nurses are expected to adhere to ethical principles and the following: Nurses who have knowledge of abuse and maltreatment of detainees and prisoners take appropriate action to safeguard their rights; do not assume functions of prison security personnel, such as body searches for the purpose of prison security; participate in clinical research on prisoners and detainees only with the prisoner or detainee's informed consent; collaborate with other health professionals and prison authorities to reduce the impact of crowded and unhealthy prison environments on transmission of infectious diseases such as HIV/AIDS and tuberculosis; abstain from using their nursing knowledge and skills in any manner, which violates the rights of detainees and prisoners; advocate for safe humane treatment of detainees and prisoners including clean water, adequate food and other basic necessities of life". This is because health professionals "have a moral duty to protect the physical and mental health of prisoners and detainees:" The ICN Code of Ethics for Nurses (Geneva 2005) affirms that "nurses have a fundamental responsibility to promote health, to prevent illness, to restore health and to alleviate suffering to all people, including detainees and prisoners. Nurses working in prison systems must observe the Standard Minimum Rules for the Treatment of Prisoners, which require that health services must be available to prisoners without discrimination."

2.5.3 General Psychiatry

The CoE-Assembly proposed the following rules concerning "problems and abuses in psychiatry" for a new recommendation: "a. the code of ethics must explicitly stipulate that it is forbidden for therapists to make sexual advances to patients; b. the use of isolation cells should be strictly limited and accommodation in large dormitories should also be avoided; c. no mechanical restraint should be used – the use of pharmaceutical means of restraint must be proportionate to the objective sought, and there must be no permanent infringement of individuals' rights to procreate; d. scientific research in the field of mental health must not be undertaken without the patient's knowledge, or against his or her will or the will of his or her representative, and must be conducted only in the patient's interest". Concerning the situation of detained persons it continues: "any person who is imprisoned should be examined by a doctor; a psychiatrist and specially trained staff should be attached to each penal institution; the rules set out above and the rules of ethics should be applied to detained persons and, in particular, medical confidentiality should be maintained in so far as this is compatible with the demands of detention; sociotherapy programmes should be set up in certain penal institutions for detained persons suffering from personality disorders" (CoE Rec 1235 [1998] par. 7 lit. a–d).

The recommendations "concerning the protection of the human rights and dignity of persons with mental disorder" aim to enhance the protection of the dignity, human rights and fundamental freedoms of persons with mental disorder, "in particular those who are subject to involuntary placement or involuntary treatment" (CoE Rec 2004(10) Guidelines art. 1) and "applies to persons with mental disorder defined in accordance with internationally accepted medical standards; lack of adaptation to the moral, social, political or other values of a society, of itself, should not be considered a mental disorder" (CoE Rec 2004(10) Guidelines art. 2). Any form of discrimination on grounds of mental disorder should be prohibited; persons with mental disorder should be entitled to exercise all their civil and political rights: "Any restrictions to the exercise of those rights should be in conformity with the provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms and should not be based on the mere fact that a person has a mental disorder" (CoE Rec 2004(10) Guidelines art. 3 and 4).

Professional staff involved in mental health services should have appropriate qualifications and training to enable them to perform their role within the services according to professional obligations and standards: "In particular, staff should receive appropriate training on: protecting the dignity, human rights and fundamental freedoms of persons with mental disorder; understanding, prevention and control of violence; measures to avoid the use of restraint or seclusion; the limited circumstances in which different methods of restraint or seclusion may be justified, taking into account the benefits and risks entailed, and the correct application of such measures" (CoE Rec 2004(10) Guidelines art. 11).

In the "Madrid Declaration on Ethical Standards for Psychiatric Practice" (2005) the World Psychiatric Association (WPA) noted that medicine is both a healing art

and a science: “The dynamics of this combination are best reflected in psychiatry, the branch of medicine that specializes in the care and protection of those who are ill or infirm, because of a mental disorder or impairment. Although there may be cultural, social and national differences, the need for ethical conduct and continual review of ethical standards is universal” (preamble par. 1). As practitioners of medicine, psychiatrists must be aware of the ethical implications of being a physician, and of “the specific ethical demands of the specialty of psychiatry: As members of society, psychiatrists must advocate for fair and equal treatment of the mentally ill, for social justice and equity for all” (par. 2). Ethical practice should be based on “the psychiatrist’s individual sense of responsibility to the patient and judgment in determining what is correct and appropriate conduct”, because “external standards and influences such as professional codes of conduct, the study of ethics, or the rule of law by themselves will not guarantee the ethical practice of medicine” (par. 3). They should keep in mind at all times “the boundaries of the psychiatrist-patient relationship, and be guided primarily by the respect for patients and concern for their welfare and integrity” (par. 4).

Psychiatrists serve patients by providing “the best therapy available consistent with accepted scientific knowledge and ethical principles” (ibid art.1). The patient should be accepted as a partner in the therapeutic process: “The psychiatrist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions” (art. 3). When psychiatrists are requested to assess a person, it is their duty “first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment”, which is particularly important when psychiatrists are involved in “third party situations” (art. 5). There are aspects in the history of psychiatry and in present working expectations in some totalitarian political regimes and profit driven economical systems, that increase “psychiatrists’ vulnerabilities to be abused in the sense of having to acquiesce to inappropriate demands to provide inaccurate psychiatric reports that help the system, but damage the interests of the person being assessed” (art. 13 par. 3). It is the duty of a psychiatrist confronted with “dual obligations and responsibilities at assessment time to disclose to the person being assessed the nature of the triangular relationship and the absence of a therapeutic doctor-patient relationship, besides the obligation to report to a third party even if the findings are negative and potentially damaging to the interests of the person under assessment” (art. 15).

Following the “Declaration of Hawaii” (WPA 1983) the psychiatrist “must never use his professional possibilities to violate the dignity or human rights of any individual or group and should never let inappropriate personal desires, feelings, prejudices or beliefs interfere with the treatment and on no account utilize the tools of his profession, once the absence of psychiatric illness has been established; if a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to cooperate” (art. 7). Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept “confidential unless the patient relieves the psychiatrist from this obligation, or to prevent serious harm to self or others makes disclosure necessary” (ibid art. 8).

The WPA "statement and viewpoints on the rights and legal safeguards of the mentally ill" (Athens 1989) was meant as "a charter on the rights of mental patients", in a way extending and complementing the Hawaii Declaration. Persons suffering from mental illness shall enjoy "the same human rights and fundamental freedoms as all other citizens" and not be "the subject of discrimination on grounds of mental illness"; they have the right to "professional, human and dignified treatment" and shall be protected "from exploitation, abuse and degradation". Clinical trials and experimental treatments shall never be carried out on patients involuntarily hospitalized. Patients who are deprived of their liberty shall have the right to a qualified guardian or counsel to protect their interests, and to free communication, limited only as strictly necessary in the interests of the health or safety of themselves or others.

2.5.4 Prison Psychiatry

Persons with mental disorder should not be subject "to discrimination in penal institutions"; in particular, the "principle of equivalence of care with that outside penal institutions should be respected with regard to their health care. They should be transferred between penal institution and hospital if their health needs so require. Appropriate therapeutic options should be available for persons with mental disorder detained in penal institutions." Involuntary treatment for mental disorder "should not take place in penal institutions except in hospital units or medical units suitable for the treatment of mental disorder"; an independent system should monitor the treatment and care of persons with mental disorder in penal institutions (CoE Rec 2004[10] art. 35; a review of "minimum standards and best practices concerning mental health and substance use services in correctional settings" can be found in: Livingston 2009).

Persons who are suffering from mental illness and whose state of mental health is incompatible with detention in a prison "should be detained in an establishment specially designed for the purpose" (EPR 12). If such persons are nevertheless exceptionally held in prison there shall be special regulations that take account of their status and needs: "Specialised prisons or sections under medical control shall be available for the observation and treatment of prisoners suffering from mental disorder or abnormality who do not necessarily fall under the provisions of Rule 12. The prison medical service shall provide for the psychiatric treatment of all prisoners who are in need of such treatment and pay special attention to suicide prevention" (EPR and Pollähne 2007).

If a person whose behaviour is strongly suggestive of mental disorder is arrested, the person "should have the right to assistance from a representative or an appropriate personal advocate during the procedure and an appropriate medical examination should be conducted promptly at a suitable location to establish: the person's need for medical care, including psychiatric care, the person's capacity to respond to interrogation and whether the person can be safely detained in non-health care facilities" (CoE Rec 2004[10] art. 33).

In the "Resolution on the Abuse of Psychiatry" (2002) the WMA notes with concern "evidence from a number of countries that political dissidents and social activists have been detained in psychiatric institutions, and subjected to unnecessary psychiatric treatment as a punishment, declares that such detention and treatment is abusive and unacceptable and calls on physicians and psychiatrists to resist involvement in these abusive practices."

The "Statement on Ethical Issues Concerning Patients with Mental Illness" (WMA 2006) included the following "ethical principles": The discrimination associated with psychiatry and the mentally ill should be eliminated; this stigma often discourages people in need from seeking psychiatric help, thereby aggravating their situation and placing them at risk of emotional or physical harm (par. 7). Every physician should offer the patient the best available therapy to his/her knowledge, and should treat the patient with the solicitude and respect due to all human beings. The physician practising in a prison "can be faced with a conflict between his/her responsibilities to society and the responsibilities to the patient", his primary loyalty and duty must be to the patient's best interest; he should ensure that the patient is made "aware of the conflict in order to minimize feelings of betrayal, and should offer the patient the opportunity to understand measures mandated by legal authority" (par. 11).

A number of mentally ill prisoners may have to be regarded as persons with disabilities in the context of the UN Convention on the Rights of Persons with Disabilities (CRPD 2006), a fact that might be forgotten or not admitted: The CRPD is to be adopted in prisons as well, naturally, whenever and wherever "persons with disabilities" are affected (art. 1 par. 1, cf. art. 13 par. 2 concerning the training of prison staff "to help to ensure effective access to justice for persons with disabilities").

2.5.5 Special Challenges for Physicians and Psychiatrists

What is there to be said about capital punishment other than the human rights obligation to abolition? "Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed" (Madrid Declaration on Ethical Standards for Psychiatric Practice, WPA 2005 art. 3), which is equally true for other physicians and nurses (cf. the WMA Resolution on Physician Participation in Capital Punishment, 2008, and the ICN Position on torture, death penalty and participation by nurses in executions, 2006 and Beck 2009).

No one shall be subjected "without his free consent to medical or scientific experimentation" (CCPR art. 7 par. 2), which is valid even more so for prisoners: "Experiments involving prisoners that may result in physical injury, mental distress or other damage to health shall be prohibited" (EPR 48; cf. the WMA Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects, 2008; for details see Chap. 5).

The prison systems in many countries mandate body cavity searches of prisoners. Such searches, which include rectal and pelvic examination, may be performed when an individual enters the prison population and thereafter whenever the individual is permitted to have personal contact with someone outside the prison population, or when there is a reason to believe a breach of security or of prison regulations has occurred. "These searches are performed for security reasons and not for medical reasons. Nevertheless, they should not be done by anyone other than a person with appropriate medical training" (WMA-Statement on Body Searches of Prisoners 2005). If the search is conducted by a physician, it should not be done by the physician who will also subsequently provide medical care to the prisoner: "The physician's obligation to provide medical care to the prisoner should not be compromised by an obligation to participate in the prison's security system." The WMA urges all governments and public officials with responsibility for public safety to recognize that such invasive search procedures are serious assaults on a person's privacy and dignity, and that they also carry some risk of physical and psychological injury. To the extent feasible without compromising public security, the WMA exhorts "alternate methods be used for routine screening of prisoners, and body cavity searches be used only as a last resort; if a body cavity search must be conducted, the responsible public official must ensure that the search is conducted by personnel with sufficient medical knowledge and skills to safely perform the search; the same responsible authority ensures that the individual's privacy and dignity be guaranteed".

Hunger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (detailed Pont and Riekenbrauck in Keppler and Stöver 2010); they are often a form of protest by people who lack other ways of making their demands known. "Genuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians" (WMA Declaration of Malta on Hunger Strikers 2006 preamble). Hunger strikers usually do not wish to die but some may be prepared to do so to achieve their aims. Physicians need to ascertain the individual's true intention, especially in collective strikes or situations where peer pressure may be a factor. "An ethical dilemma arises when hunger strikers who have apparently issued clear instructions not to be resuscitated reach a stage of cognitive impairment", because the principle of beneficence urges physicians to resuscitate them "but respect for individual autonomy restrains physicians from intervening when a valid and informed refusal has been made". An added difficulty arises in custodial settings, "because it is not always clear whether the hunger striker's advance instructions were made voluntarily and with appropriate information about the consequences" (WMA Declaration of Malta on Hunger Strikers 2006 preamble).

In this context the WMA set up principles, that reach beyond the topic: "All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy: Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs; hunger strikers should not be forcibly given treatment they refuse: Forced feeding contrary to an informed and voluntary refusal is unjustifiable - artificial feeding with

the hunger striker's explicit or implied consent is ethically acceptable; physicians must exercise their skills and knowledge to benefit those they treat: This is the concept of 'beneficence', which is complemented by that of 'non-maleficence' or primum non nocere. These two concepts need to be in balance. 'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm' means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting; physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients: Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient; physicians must remain objective in their assessments and not allow third parties to influence their medical judgement: They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons" (The WMA-Tokyo-Declaration 2006, art. 6).

References

Alfredsson, G., and K. Tomaševski (eds.). 1998. *A thematic guide to documents on health and human rights*. The Hague: Nijhoff.

American Association for Correctional Psychology (ed.). 2010. *Standards for psychology in jails, prisons, correctional facilities, and agencies*. Alexandria: ACA. http://www.eurekalert.org/pub_releases/2010-07/sp-rsf070810.php. Accessed 17 Aug 2010.

Banks, C. 2009. *Criminal justice ethics: Theory and practice*, 2nd ed. Thousand Oaks: Sage.

Beck, W. 2009. Beteiligung von Ärzten an Folter und Todesstrafe. Menschenrechte, Berufsethik und Rollenkonflikte. In *Folter und ärztliche Verantwortung*, ed. H. Furtmayr, K. Krása, and A. Frewer. Göttingen: Unipress.

Beckett, K. 1997. *Making crime pay. Law and order in contemporary American politics*. New York: Oxford University Press.

Boonin, D. 2008. *The problem of punishment*. Cambridge: Cambridge University Press.

Christie, N. 2000. *Crime control as industry. Towards gulags, western style*, 3rd ed. London/New York: Routledge.

Council of Europe (CoE) Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Oviedo-Convention on Human Rights and Biomedicine). 1997. http://www.coe.int/t/dg3/healthbioethic/Activities/01_Oviedo%20Convention/

CoE-Assembly-Recommendation concerning Problems and Abuses in Psychiatry. 1998. http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta94/EREC1235.htm

CoE-Recommendation concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder. 2004. http://www.coe.int/t/dg3/healthbioethic/texts_and_documents/Rec(2004)10_e.pdf

Davis, A.Y. 2003. *Are prisons obsolete?* New York: Seven Stories Press.

Decaire, M. (undated). *Ethical concerns in correctional psychology*. http://www.uplink.com.au/lawlibrary/Documents/Docs/Doc93.html. Accessed 17 Aug 2010.

Dostojewski, F. 1860. *The house of the dead*. London: Penguin.

Downes, D. 2001. The *macho* penal economy. In *Mass imprisonment*, ed. D. Garland. London: Sage.

European Charter of Patients' Rights. 2002. http://www.activecitizenship.net/content/blogcategory/32/77/

European Committee for the Prevention of Torture (CPT) Standards. 2002, rev. 2009. http://www.cpt.coe.int/en/documents/eng-standards-scr.pdf
European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR). 1950. http://conventions.coe.int/treaty/Commun/QueVoulezVous.asp?NT=005&CL=ENG
European Prison Rules (EPR). 2006. https://wcd.coe.int/ViewDoc.jsp?id=955747
Foucault, M. 1995. *Discipline and punish*. New York: Vintage.
Frewer, A., and H. Furtmayr. 2007. *Istanbul-Protokoll: Untersuchung und Dokumentation von Folter und Menschenrechtsverletzungen*. Göttingen: V&R Unipress.
Garland, D. 2001. *The culture of control. Crime and social order in contemporary society*. Oxford: Oxford Universrity Press.
Goffman, E. 1968. *Asylums*. Harmondsworth: Penguin.
International Council of Nurses (ICN) Position on Nurses' Role in the Care of Detainees and Prisoners. 2005. http://www.icn.ch/images/stories/documents/publications/position_statements/A13_Nurses_Role_Detainees_Prisoners.pdf
ICN-Code of Ethics for Nurses (Geneva). 2005. http://www.icn.ch/about-icn/code-of-ethics-for-nurses/
ICN-Position on Torture, Death Penalty and Participation by Nurses in Executions. 2006. http://www.icn.ch/images/stories/documents/publications/position_statements/E13_Torture_Death_Penalty_Executions.pdf
Kallert, T.W., and F. Torres-Gonzáles (eds.). 2006. *Legislation on coercive mental health care in Europe*. Frankfurt: Peter Lang.
Keppler, K., and H. Stöver (eds.). 2010. *Gefängnismedizin*. Stuttgart: Thieme.
Keppler, K., H. Stöver, B. Schulte, and J. Reimer. 2010. Prison health is public health. *Bundesgesundheitsblatt* 53: 233–244.
Kleinig, J. 2008. *Ethics and criminal justice: An introduction*. Cambridge: Cambridge University Press.
Kury, H., and T.N. Ferdinand (eds.). 2008. *International perspectives on punitivity*. Bochum: Brockmeyer.
Liebling, A., and H. Arnold. 2004. *Prisons and their moral performance: A study of values, quality, and prison life*. Oxford: Oxford University Press.
Lippke, R.L. 2007. *Rethinking imprisonment*. Oxford: Oxford University Press.
Livingston, J.D. 2009. *Mental health and substance use services in correctional settings. A review on minimum standards and best practices*. Vancouver: International Centre for Criminal Law – Reform and Criminal Justice Policy. www.icclr.law.ubc.ca. Accessed 16 Aug 2010.
Mahmood, M. 2004. Collateral consequences of the prison industrial complex. *Social Justice* 31: 31–34.
McMahon, M. 1997. Kontrolle als Unternehmen. *Widersprüche* 17: 25–36.
Mehigan, J., and A. Rowe. 2007. Problematizing prison privatization: An overview of the debate. In *Handbook on prisons*, ed. Y. Jewkes. Portland: Willan.
Morgan, R., and M. Evans. 2003. *Bekämpfung der Folter in Europa*. Berlin: Springer.
O'Connor, T. 2006. *Correctional ethics*. www.apsu.edu/oconnort/3300/3300lect06.htm. Accessed 17 Aug 2010.
Pollähne, H. 2007. Der CPT-Bericht über den Deutschland-Besuch 2005. *Recht und Psychiatrie* 25: 120–131.
Pollähne, H. 2010. New economies in the prison system. In *Komplemente in Sachen: Kriminologie, Drogenhilfe, Psychotherapie, Kriminalpolitik*, ed. H. Pollähne and H. Stöver. Berlin: Lit.
Pollock, J.M. 2004. *Ethics in crime and justice*, 4th ed. Belmont: Wadsworth.
Pollock, J.M., and R.F. Becker. 1995. Law enforcement ethics: Using officers' dilemmas as a teaching tool. *Journal of Criminal Justice Education* 6: 1–20.
Schmalleger, F., and Smylka, J.O. 2008. *Corrections in the 21st Century – Ethical Dilemmas*. www.justicestudies.com/ethics04. Accessed 17 Aug 2010.
Sissons, P.L. 1976. The place of medicine in the American prison: Ethical issues in the treatment of offenders. *Journal of Medical Ethics* 2: 173–179.

Stern, V. 2006. *Creating criminals. Prisons and people in a market society*. London/New York: Zed Books.
Sudbury, J. 2004. A world without prisons: Resisting militarism, globalized punishment, and empire. *Social Justice* 31: 9–30.
UN: International Covenant on Civil and Political Rights (CCPR). 1966. http://www2.ohchr.org/english/law/ccpr.htm
UN-Convention Against Torture (CAT). 1984. http://www.un.org/documents/ga/res/39/a39r046.htm
UN-Convention on the Elimination of all Forms of Racial Discrimination (CERD). 1965. http://www2.ohchr.org/english/law/cerd.htm
UN-Convention on the Rights of Persons with Disabilities (CRPD). 2006. http://www.un.org/disabilities/convention/conventionfull.shtml
UN-Covenant on Economic, Social and Cultural Rights (CESCR). 1966. http://www2.ohchr.org/english/law/cescr.htm
UN-Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. 1999. http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf
Universal Declaration of Human Rights. 1948. http://www.un.org/en/documents/udhr/
UTMB Institute for Medical Humanities. 2007. *Program on legal and ethical issues in correctional health*. www.utmb.edu/imh/CorrectionalHealth/law.asp. Accessed 17 Aug 2010.
van Zyl-Smit, D., and F. Dünkel (eds.). 2001. *Imprisonment today and tomorrow. International perspectives on prisoners' rights and prison conditions*. The Hague: Kluwer Law.
Wacquant, L. 2008. The place of the prison in the new government of poverty (prisons of poverty). In *After the war on crime: Race, democracy, and a reconstruction*, ed. M.L. Frampton et al. New York: New York University Press.
Weber, M. 1930. *The protestant ethic and the spirit of capitalism*. New York: Scribner's.
World Medical Association (WMA) International Code of Medical Ethics. (rev. 2006). http://www.wma.net/en/30publications/10policies/c8/index.html
WMA-Declaration on Ethical Principles for Medical Research Involving Human Subjects (Helsinki). 2008. http://www.wma.net/en/30publications/10policies/b3/index.html
WMA-Declaration of Geneva. 2006. http://www.wma.net/en/30publications/10policies/g1/
WMA-Declaration on Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Tokyo). 2006. http://www.wma.net/en/30publications/10policies/c18/index.html
WMA-Declaration on Hunger Strikers (Malta). 2006. http://www.wma.net/en/30publications/10policies/h31/index.html
WMA-Declaration on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases (Edinburgh). 2000. http://www.wma.net/en/30publications/10policies/p28/index.html
WMA-Declaration on Professional Autonomy and Self-Regulation (Madrid). 2009. http://www.wma.net/en/30publications/10policies/20archives/a21/index.html
WMA-Declaration on Support for Medical Doctors Refusing to Participate in or to Condone the use of Torture or other Forms of Cruel, Inhuman or Degrading Treatment (Hamburg). 1997. http://www.wma.net/en/30publications/10policies/c19/index.html
WMA-Resolution on Physician Participation in Capital Punishment. 2008. http://www.wma.net/en/30publications/10policies/c1/index.html
WMA-Resolution on Prohibition of Physician Participation in Torture (Tel Aviv). 2009. http://www.wma.net/en/30publications/10policies/30council/cr_8/index.html
WMA-Resolution on Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of which they are Aware. 2007. http://www.wma.net/en/30publications/10policies/t1/index.html
WMA-Resolution on the Abuse of Psychiatry. 2002. http://www.wma.net/en/30publications/10policies/a3/index.html
WMA-Statement on Body Searches of Prisoners. 2005. http://www.wma.net/en/30publications/10policies/b5/index.html

WMA-Statement on Ethical Issues Concerning Patients with Mental Illness. 2006. http://www.wma.net/en/30publications/10policies/e11/index.html
World Psychiatric Association (WPA) Declaration on Ethical Standards for Psychiatric Practice (Madrid). 2005. http://www.wpanet.org/detail.php?section_id=5&content_id=48
WPA-Declaration of Hawaii. 1983. http://www.wpanet.org/detail.php?section_id=5&content_id=27
WPA-Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill (Athens). 1989. http://www.wpanet.org/detail.php?section_id=5&content_id=29
Zedner, L. 2004. *Criminal justice*. Oxford: Oxford University Press.