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ORIGINAL RESEARCH

Ethics, the Law, and Prisoners: Protecting Society, Changing Human Behavior, and Protecting Human Rights

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Abstract Restricting a person's liberty presents society with many inherent ethical challenges. The historical purposes of confinement have included punishment, penitence, containment, rehabilitation, and habilitation. While the purposes are indeed complex, multifaceted, and at times ambiguous or contradictory, the fact of incarceration intrinsically creates many ethical challenges for psychiatrists working in correctional settings. Role definition of a psychiatrist may be ambiguous, with potential tensions between forensic and therapeutic demands. Privacy may be limited or absent and confidentiality may be compromised. Patient autonomy may be threatened to address real or perceived security concerns. Care delivery may actually have harmful consequences in court cases for pretrial detainees or lethal consequences for those under a death sentence. An absence of data and targeted research hampers the development of evidence-based care delivery for the disenfranchised, understudied, and disproportionately ill prisoner population. In this review paper, I discuss a few of the challenges and dilemmas routinely faced and present a series of questions. Where feasible, proposed resolutions are offered.

Keywords Psychiatry · Challenges · Human rights · Pragmatics · Prosocial · Ethical behavior

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Introduction

Restricting a person's liberty presents society with many inherent ethical challenges. The historical purposes of confinement have included punishment, penitence, containment, rehabilitation, and habilitation. While the purposes are indeed complex, multifaceted, and at times ambiguous or contradictory, the fact of incarceration intrinsically creates many ethical challenges for psychiatrists working in correctional settings (Restellini and Restellini 2014). In this review paper, I discuss a few of the challenges and dilemmas routinely faced in this context and present a series of questions. Where feasible, proposed resolutions are offered. While many of these issues are relevant worldwide, the situation and ethical challenges of prison psychiatry are addressed from a U.S. perspective. The aim of the paper is to stimulate further interdisciplinary discussion between health care practitioners and ethics scholars in order to find acceptable solutions.

Prisons: Purposes and Practice

Over the decades and centuries, prisons have served many social and political purposes. The role of the prison in keeping society safe by containing violent felons has been a constant. Which other crimes (particularly nonviolent ones) justify confinement, what duration of confinement, and what purposes beyond containment incarceration should serve have shifted considerably over time and across jurisdictions. The Standard

Minimum Rules for the Treatment of Prisoners asserts that

> the purpose and justification of a sentence of imprisonment … is ultimately to protect society against crime. This end can only be achieved if the period of imprisonment is used to ensure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life. … [T]reatment shall be such as will encourage their [imprisoned persons'] self-respect and develop their sense of responsibility (United Nations 1977, Rules 58 and 65).

While the role of incarceration may evolve and be an important focus for debate, I would argue that one central tenet seems to be consistent in legal and ethical perspectives: Confinement and restriction of liberty is the punishment. Conditions of confinement should not be debasing or dehumanizing, and access to health care and the quality of that health care should not differ from that which is available in the community, a principle also referred to as "equivalence of care" (Jotterand and Wangmo 2014; Elger 2008).

While health care is considered a human right in parts of the developed world (such as most of Europe) that perspective is not universal. An obvious exception is the lack of access to health care for citizens in the community in many jurisdictions or nations, such as is the case in the United States. For this reason the American Psychiatric Association has published recommendations that psychiatric care in jails and prisons be held to the standard of what "should be available" in the community, as opposed to the standard of what actually is available (American Psychiatric Association 2000, 6). Beyond confinement per se, almost every interaction leads to the potential for ethical concerns as they relate to psychiatric care and psychiatrist involvement (Birmingham, Wilson, and Adshead 2006).

International Human Rights Law

Human rights are central to our consideration of correctional psychiatry. The rights of human dignity, rehabilitation, mental health treatment, and freedom from torture or other cruel treatment or punishment are each relevant and critical to correctional ethics. These rights are affirmed in the International Covenant on Civil and Political Rights (ICCPR) (United Nations 1966a), the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (United Nations 1984), and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (United Nations 1966b). More specifically, multiple national and international medical organizations years ago affirmed the ethical obligation of physicians to refrain from countenancing, tolerating, or participating in cruel, inhumane, or degrading treatment or outright torture (World Psychiatric Association 1996; American Medical Association 1978; World Medical Association 1997). More recently, the National Commission on Correctional Health Care (NCCHC) in the United States issued a parallel position statement that correctional health care professionals "should not condone or participate in cruel, inhumane, or degrading treatment of inmates" (National Commission on Correctional Health Care 2007, Principle 2). The fact that such a statement was issued so recently suggests that the concerns of human rights violations are current, significant, and culturally normative.

Beyond nonmaleficence, there are also affirmative expectations. A prisoner's right to health is violated when a medical condition worsens significantly due to lack of prompt and appropriate illness identification and treatment (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 2011; Abramsky and Fellner 2003). The right to health may also be violated when prisoners are kept in facilities without proper staffing and resources to provide proper specialized treatment for an illness (*Taddei v. France*, No. 36435/07, European Court of Human Rights [2010]; Abramsky and Fellner 2003). In the remainder of this article, some of the most pressing ethical challenges are discussed. The intent here is to present the array of complex situational demands that create the context for carceral mental health care delivery.

Equivalence of Care

The general expectation in developed countries is that medical and mental health care in correctional settings should be equivalent to that which is available in the community (United Nations Committee on Economic and Social and Cultural Rights 2000; Council of Europe Committee of Ministers 2006; *Estelle v. Gamble*, 429

U.S. 97 [1976]; *Bowring v. Godwin*, 551 F.2d 44 [1977]). Setting aside actual availability of access to treatment in the community for the moment, the intent of using a community standard is to affirm that incarceration should not diminish the health and the needed health care of the individual. As a consequence of funding limitations and cultural attitudes, such expectations are often unmet. Such challenges are not limited to the United States: The National Offender Management Service, responsible for the prisons in England and Wales, faces a budget cut totaling 25 percent between 2011 and 2015 (Prison Reform Trust 2014). If the community standard itself is inadequate, though, people in the community at least have the freedom to seek alternatives. Not so in prisons. So, when a prison meets the standard of equivalence that exists in the surrounding community, but that standard is below an acceptable level, is that acceptable? It is that context that led the American Psychiatric Association to assert that mental health treatment in jails and prisons is expected to meet a standard of care that "should be available in the community" (American Psychiatric Association 2000, 6). However, it remains unclear how best to define, assess, and manage situations where equivalence of care is deficient.

Access to Care

As mentioned above, equivalence of care is a critical and often lacking element. However, even when such equivalence exists, access to care in reality may be very limited. Insufficient or delayed treatment can also constitute cruel, inhuman, or degrading treatment. Such treatment access failures might be by deliberate design or indifference or may be consequent to negligence. Either way, impaired access to appropriate health care can "lead rapidly to situations falling within the scope of the term 'inhuman and degrading treatment'" (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 2011, 38). The defining characteristic is prisoner suffering: Did staff absence or behavior cause or aggravate the suffering due to illness? For example, bureaucratic impediments and hurdles may by design limit access. Examples include: written requests for care placed in a request box that is only checked monthly; requests being routinely denied, forcing patients who wish to pursue care to engage in an administrative process of appeals that regularly delays access to mental health assessment; understaffing creating interminable waiting lists; or custodial staff limiting prisoners' ability to submit care requests. What role does psychiatry play in addressing these failures? How might psychiatrists best exercise their professional responsibilities to shape a system that eliminates impediments? How active must a psychiatrist be in such advocacy?

Confidentiality

Confidentiality of communication and of the medical record is the bedrock of a therapeutic relationship between patient and psychiatrist. In contrast to psychiatric clinics and hospitals, many correctional institutions are not designed to provide ready access to safe, private rooms for assessment and therapy. Correctional environments often allow or encourage cell-side conversations between psychiatrist and patient due to expressed limitations of time (e.g., "It takes too long to get someone released from the cell") or location (e.g., "I have no place to meet privately"). Clearly, such issues have no traction ethically. The challenge herein, as with so many concerns, is the interface of ethics and reality—how to reshape a system of confinement and care delivery to provide adequate function and programmatic space. Should correctional health care personnel agree to work under unethical conditions because detainees would receive no care at all if they did not do so?

Informed Consent and the Ability to Refuse Treatment

Having access to care is crucial and is a systems issue; working with a patient and informing him or her of treatment options is a one-on-one therapeutic issue. It addresses the core concern of a person's autonomy. In the community, there has been a shift in recent decades away from paternalism and toward the right to autonomy—including the right of a patient to refuse treatment. This is linked to the presumption of a capacity to make a meaningful choice. This presumption rests on several elements: the intellectual capacity of the individual, the adequacy of the information provided, and the policies that allow for free choice. When capacity is impaired, and the treating psychiatrist believes psychotropic medication is needed to treat serious mental illness, there are

standards for treatment against will in the community. These standards have been considered by courts in the United States. For convicted prisoners, the standard often applied allows for medication against will and includes protections such as prior notification, the ability to call witnesses, and the right of appeal (Dlugacz and Wimmer 2013). Even in the context of these protections, the security concerns of the correctional system take precedence. For pretrial detainees, the right to a fair trial has generally prevailed, but is still an issue of substantial legal debate. The concern includes whether treatment against one's will impacts the outcome of the trial, whether the rights of the detainee (still presumed innocent) are being honored, and whether in so doing the security of the facility and its other detainees may be compromised (Appelbaum 2012; Felthous 2012; Dlugacz and Wimmer 2013). When is it ethical to treat someone against his or her will: Should the same standards apply universally? When the rules for intervention are context specific (for example, community hospital, pretrial detainee, convicted prisoner), does that abrogate the basic autonomy of the individual in favor of the needs of the state? What guidelines are ethically defensible?

Roles of the Psychiatrist

The requirements for care delivery in carceral settings are essentially the same as in the community. Keeping a clear boundary between forensic evaluation and care delivery is critical in prisons and jails. For example, a psychiatrist might be asked to determine whether an inmate under his or her care was psychotic at the time of the alleged crime. In the detached role of a forensic examiner, this is an appropriate question. In the role of a correctional psychiatrist, it is an unacceptable breach of the patient–doctor relationship.

Psychiatry should be challenged to take a broader role in the ethical delivery of care: How can the psychiatrists diminish pain and suffering and empower the individual to function well in society?

Segregation

Isolating an individual from meaningful human contact has long been seen as a punishment. In recent years, the use of isolation, also called solitary confinement or segregation, has increased in the United States and elsewhere (Metzner and Fellner 2010; Coyle 2002). No medical organization advocates such isolation, but psychiatrists are frequently called upon to support or provide care for those confined in these conditions. Prisoners with mental illness may decompensate in isolation, requiring crisis care or psychiatric hospitalization. Conversely, it is rare that those with mental illness improve in this context, abrogating the demand for beneficence (Metzner and Fellner 2010; Abramsky and Fellner 2003). Mental health services are typically limited to psychotropic medication, periodic visits at the cell door to ask how the prisoner is doing, and occasional private meetings (Metzner and Dvoskin 2006).

International treaty bodies and human rights experts, including the UN Human Rights Committee (1992, 2006), the UN Committee Against Torture (2006), the UN Special Rapporteur on Torture (United Nations General Assembly 2011), and the European Committee for the Prevention of Torture (2011), have concluded that solitary confinement may amount to torture or other cruel, inhuman, or degrading treatment or punishment. Acknowledging the damaging consequences on mental health from prolonged isolation, they have insisted that if and when solitary confinement must be imposed, it should be for as short a period of time as possible. Others note that reliance on isolation as a management technique reflects poor management of the prison itself and is damaging to the humanity of both staff and prisoners (Coyle 2002).

The American Psychiatric Association recently adopted the following position statement:

> Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals (American Psychiatric Association 2012, para. 1).

The Society for Correctional Physicians also recently issued a similar position statement (Society of Correctional Physicians 2013).

Given that, the ethical challenge is really addressing not only the "how," but the "why": Why do people need to be held in isolation? What is the goal of such confinement? Yet there is a clear lack of research regarding the effects of isolation on individual behavior. What are the parameters of relevance: Does it indeed act as a punishment in behavioral terms, i.e., decreasing the frequency of unwanted behavior? Would research on confinement that lasts months or years be ethical given the psychological harm caused by such measures? How could evidence from the educational sciences that has shown clearly that punishment is a rather ineffective means to change behavior compared to positive incentives be more widely applied to prison systems?

Sanctions

Whether in the community or in prison, people may misbehave. During incarceration, a formal process typically ensues following an incident, with some manner of investigation and penalty for those found guilty of, for example, fighting, assault, or disobeying a direct order. A dilemma in this context is the potential involvement of a psychiatrist in this process. Clearly, it is ethically inappropriate for a psychiatrist to participate in deciding what punishment should be given to an inmate (American Psychiatric Association 2000). However, should a psychiatrist evaluate the prisoner to determine whether mental illness contributed to the misbehavior in the first place? Interestingly, while a U.S. federal court ruling supports allowing mental health clinician input for purposes of mitigation in the disciplinary process to protect prisoners with mental illness from inappropriate punishment (*Coleman v. Wilson*, 912 F. Supp. 1282 at 1308, [1995]), a recent U.S. district court case questioned whether federal law would prohibit prison officials from punishing "prisoners for behavior they cannot control" (*Matz v. Vandenbook*, U.S. Dist. LEXIS 116930 [2013]). Should the psychiatrist argue that the prisoner's mental illness, even when it did not contribute to the offense, is such that the prisoner may not be able to tolerate the sanction or punishment (such as deprivation of contact visits or phone calls or a period in isolation)? By so doing for some individuals, is the psychiatrist complicit in approving punishment for others? This issue challenges both ethical and pragmatic concerns. Even if the psychiatrist does not cross the boundary of recommending punishment, by arguing for psychiatric compromise in one patient and not in another there is nevertheless participation in the punishment process. Would this not compromise any future patient–doctor relationship? To what degree does this force the psychiatrist, however indirectly, into accepting that punishment is an appropriate intervention? A solution to this challenge logically derives from decades of research in shaping human behavior: Build a correctional culture that uses reinforcement rather than punishment to help build pro-social skills (e.g., Andrews and Bonta 2010; Bourgon and Armstrong 2005). In so doing, human dignity is affirmed and human rights are protected.

Restraint

The community-based use of therapeutic restraints has diminished substantially over the past decade, as alternative approaches, including de-escalation and prevention, have been emphasized and implemented. The same has not in general occurred in correctional settings. Mechanical restraint, whether with handcuffs and shackles, restraint chairs, or restraint beds, is a common practice for misbehavior and for psychiatric crisis. In the latter case, such as acute psychotic aggression or active unremitting self-injurious behavior, there are reasonable arguments for closely monitored, short-term use of restraints that are consistent with community standards (National Commission on Correctional Health Care 2008). The ethical challenge emerges for the psychiatrist in situations where the issues are less clearly psychiatric, more behavioral or explicitly punitive in response to previous behavior. The Standard Rules for Minimum Practice specifies that restraint is never to be used as punishment (United Nations 1977, Rule 33). The boundaries are more easily defined in theory than in practice, however. A potential question is what benefits, if any, come from restraining prisoners for any but the most extreme active and ongoing behaviors? As with isolation, I am not aware of any research data reflecting benefits on the use of restraints beyond the acute need to prevent harm to others or to be able to start psychiatric treatment. In both cases, the period for justified restraint would be very short. Also, alternative, more time-consuming management without restraints might

frequently be possible if staffing is adequate—for example, using persuasion and building on a trust-based relationship established between health care personnel and psychiatrically ill detainees. How should psychiatrists react to the fact that a disproportionate number of prisoners who are mentally ill or are from disenfranchised minorities are so restrained (Bersot and Arrigo 2011)? What damage is done to the officers and staff, as well as to prisoners, by supporting a culture that routinely uses mechanical restraint?

The Death Sentence and Competence for Execution

The United States is one of 58 countries with the death penalty (Amnesty International 2014). U.S. law requires that the individual to be executed must be mentally competent at the time of execution (Shannon and Scarano 2013). For someone with serious mental illness, this may require treatment to restore someone to competence. This obviously places a treating psychiatrist in an ethical bind: leave the patient untreated, suffering, but alive or treat to restore competence and thus enable the state to proceed with execution. It has been well argued that the near-universal opinion is that treatment with the "purpose or inevitable effect" of enabling that person's execution is unethical unless the prisoner had (during a prior period of competence) given an advance directive or there is a compelling need to reduce severe suffering (Bonnie 2005). One proposed resolution to this ethical challenge was developed in the U.S. state of Maryland: Commute a death sentence to life imprisonment without possibility of parole for those who are deemed incompetent for execution due to serious mental illness (Md. Code Ann., Correctional Services §3-904 [2012]). While this resolution has not been accepted as a national standard, it has seen growing acceptance in some other jurisdictions. Even with broad acceptance of this doctrine, the ethical challenges of treating a competent person who has been sentenced to death still persist, as does the underlying and more fundamental issue of the ethical probity of a death sentence. How should a psychiatrist approach care and care delivery to someone awaiting execution? Should the fact that, in the United States alone, 144 people condemned to death following a conviction have been found innocent and released since 1973 affect how psychiatry deals with mental illness in those awaiting execution (Death Penalty Information Center 2014)?

Research

After decades of delay, the United States created regulations in 1974 intended to eliminate research abuse that dramatically restricted prisoner research globally (45 C.F.R. pt 46 [2009]). These were updated following the release of the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979), officially entitled, "Ethical Principles and Guidelines for the Protection of Human Subjects of Research." (Title 45, Part 46 of the Code of Federal Regulations deals with prisoner research in Subpart C and is usually referred to as 45 C.F.R. pt 46, Subpart C). The permitted research was, and is, extremely limited. While generated with excellent intentions, and indeed eliminating the then-extant substantial and pervasive abuses, Subpart C has created a population of individuals that is now overprotected and understudied according to an extensive report by the Institute of Medicine (Gostlin, Vanchieri, and Pope 2007). The need for an expanded research base in mental illness of incarcerated populations spans every domain: epidemiology, contextually optimized psychotherapy and psychopharmacology, behavior management, skills training, effective transition to the community, and more (Cislo and Trestman 2013). This is due to the facts that prisoners are a population at high risk for disproportionate disease burden, current treatments are rarely evidence based, treatments suffer very low adherence and retention rates, the morbidity and mortality of the mentally ill upon release to the community are very high, and reincarceration rates of the mentally ill are disproportionately high as well. Nevertheless, ethical challenges for the conduct of research persist at multiple levels. These challenges in turn may be resolved through an agenda of ethical inquiry (Christopher et al. 2011). The ethical concerns proposed for this agenda include decisional capacity of the prisoner, potentially coercive influences on research, the misconception that research is indeed treatment, conflicts of interests related to the investigator perspective, and appropriate institutional review board oversight of research. Indeed, the review by Christopher et al. (2011) suggests that these concerns are definable, measurable, and addressable. Others also have reflected upon the positive benefits of appropriate research participation, even in a study as sensitive as interviews following near-lethal suicide attempts (Rivlin et al. 2012). An overarching concern not directly addressed in these discussions

is the ethical obligation of psychiatry to actively push for a culture that supports a research agenda. How is it that we can know that the care we provide is optimally benefitting our imprisoned patients unless we study and test the process and outcomes? If evidence-driven medicine is the gold standard outside detention, the principle of equivalence would imply that psychiatric care during detention also must be evidence based. It is ethically unacceptable and economically ill-advised to simply deliver care within a system that does not actively and vigorously evaluate the benefit or lack thereof of the care provided. How should generally overworked correctional psychiatrists react to the fact that it is unethical to deliver care without having benchmarks to determine effectiveness and progress?

Conclusion

Delivery of mental health care in correctional settings is intrinsically challenging. Role definition of a psychiatrist may be ambiguous, with potential tensions between forensic and therapeutic demands. Privacy may be limited or absent and confidentiality may be compromised. Patient autonomy may be threatened to address real or perceived security concerns. Care delivery may actually have harmful consequences in court cases for pretrial detainees or lethal consequences for those under a death sentence. An absence of data and targeted research hampers the development of evidence-based care delivery for the disenfranchised, understudied, and disproportionately ill prisoner population. Clarification of the ethical concerns through debate, discourse, and research is indicated. Correctional psychiatrists should not be left alone to struggle with ethical problems. It is the task of all psychiatrists to find and promote ethically acceptable solutions in the field of correctional psychiatry. Defining equivalence of care and appropriate ethical conduct of health care personnel in correctional institutions is a task that should not be left to an often isolated subgroup of professionals who often lack professional independence from the detention authorities, contrary to standards set by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (Elger 2008, 2011). Professional associations related to medicine and psychiatry such as the American Medical Association and American Psychiatric Association need to encourage wider ethical discourse and engage national and international ethical experts in order to provide clear guidance that is in line with international standards of medical ethics.

References

Abramsky, S., and J. Fellner. 2003. *Ill-equipped: U.S. prisons and offenders with mental illness*. New York: Human Rights Watch. http://www.hrw.org/reports/2003/usa1003/usa1003.pdf. Accessed May 25, 2014.

American Medical Association. 1978. Health and ethics policies of the AMA House of Delegates. http://www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf. Accessed May 25, 2014.

American Psychiatric Association. 2000. *Psychiatric services in jails and prisons*, 2nd ed. Arlington, VA: American Psychiatric Association.

American Psychiatric Association. 2012. Position statement on segregation of prisoners with mental illness. http://www.psychiatry.org/File%20Library/Learn/Archives/ps2012_PrisonerSegregation.pdf. Accessed May 25, 2014.

Amnesty International. 2014. Abolitionist and retentionist countries. http://www.amnesty.org/en/death-penalty/abolitionist-and-retentionist-countries. Accessed May 28, 2014.

Andrews, D.A., and J. Bonta. 2010. *The psychology of criminal conduct*, 5th ed. New Providence, NJ: Elsevier.

Appelbaum, P.S. 2012. Law and psychiatry: Treatment of incompetent, dangerous criminal defendants: Parsing the law. *Psychiatric Services* 63(7): 630–632.

Bersot, H.Y., and B.A. Arrigo. 2011. The ethics of mechanical restraints in prisons and jails: A preliminary inquiry from psychological jurisprudence. *Journal of Forensic Psychology Practice* 11(2–3): 232–264.

Birmingham, L., S. Wilson, and G. Adshead. 2006. Prison medicine: Ethics and equivalence. *The British Journal of Psychiatry* 188(1): 4–6.

Bonnie, R.J. 2005. Mentally ill prisoners on death row: Unsolved puzzles for courts and legislatures. *Catholic University Law Review* 54(4): 1169–1313.

Bourgon, G., and B. Armstrong. 2005. Transferring the principles of effective treatment into a "real world" prison setting. *Criminal Justice and Behavior* 32(1): 3–25.

Christopher, P.P., P.J. Candilis, J.D. Rich, and C.W. Lidz. 2011. An empirical ethics agenda for psychiatric research involving prisoners. *American Journal of Bioethics Primary Research* 2(4): 18–25.

Cislo, A.M., and R. Trestman. 2013. Challenges and solutions for conducting research in correctional settings: The U.S. experience. *International Journal of Law and Psychiatry* 36(3–4): 304–310.

Coyle, A. 2002. *A human rights approach to prison management: Handbook for prison staff*. London: International Centre for Prison Studies. http://www.prisonstudies.org/resources/human-rights-approach-prison-management-handbook-prison-staff-first-edition-english. Accessed May 25, 2014.

Council of Europe Committee of Ministers. 2006. European prison rules. https://wcd.coe.int/ViewDoc.jsp?id=955747. Accessed May 25, 2014.

Death Penalty Information Center. 2014. Innocence: List of those freed from death row. http://www.deathpenaltyinfo.org/

innocence-list-those-freed-death-row. Accessed May 30, 2014.

Dlugacz, H., and C. Wimmer. 2013. Legal aspects of administrating antipsychotic medications to jail and prison inmates. *International Journal of Law and Psychiatry* 36(3): 213–228.

Elger, B.S. 2008. Towards equivalent health care of prisoners: European soft law and public health policy in Geneva. *Journal of Public Health Policy* 29(2): 192–206.

Elger, B.S. 2011. Prison medicine, public health policy and ethics: The Geneva experience. *Swiss Medical Weekly* 141: w13273. doi:10.4414/smw.2011.13273.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. 2011. *CPT standards*. Strasbourg: Council of Europe. http://www.cpt.coe.int/en/documents/eng-standards.pdf. Accessed December 18, 2013.

Felthous, A.R. 2012. The involuntary medication of Jared Loughner and pretrial jail detainees in nonmedical correctional facilities. *The Journal of the American Academy of Psychiatry and the Law Online* 40(1): 98–112.

Gostlin, L.O., C. Vanchieri, and A. Pope. 2007. *Ethical considerations for research involving prisoners*. Washington, DC: Institute of Medicine, National Academies Press.

Jotterand, F., and T. Wangmo. 2014. The principle of equivalence reconsidered: Assessing the relevance of the principle of equivalence in prison medicine. *The American Journal of Bioethics* 14(7): 1–8.

Metzner, J., and J. Dvoskin. 2006. An overview of correctional psychiatry. *Psychiatric Clinics of North America* 29(3): 761–772.

Metzner, J.L., and J. Fellner. 2010. Solitary confinement and mental illness in U.S. prisons: A challenge for medical ethics. *The Journal of the American Academy of Psychiatry and the Law* 38(1): 104–108.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. *The Belmont report: Ethical principles and guidelines for the protection of human subjects of research*. Washington, DC: Office for Protection From Research Risks. http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html. Accessed May 30, 2014.

National Commission on Correctional Health Care. 2007. Position statement: Correctional health care professionals' response to inmate abuse. http://www.ncchc.org/correctional-health-care-professionals%E2%80 %99-response-to-inmate-abuse. Accessed May 25, 2014.

National Commission on Correctional Health Care. 2008. *Standards for mental health services in correctional facilities*. Chicago: National Commission on Correctional Health Care

Prison Reform Trust. 2014. *Prison: The facts*. London: Prison Reform Trust. http://www.prisonreformtrust.org.uk/Portals/0/Documents/Prison%20the%20facts%20May%202014.pdf?dm_i=47 L,2GWMH,1KH8TB,8ZHO8,1. Accessed May 29, 2014.

Restellini, J.P., and R. Restellini. 2014. Prison-specific ethical and clinical problems. In *Prisons and health*, edited by S. Enggist, L. Møller, G. Galea, and C. Udesen, 11–18. Copenhagen: World Health Organization.

Rivlin, A., L. Marzano, K. Hawton, and S. Fazel. 2012. Impact on prisoners of participating in research interviews related to near-lethal suicide attempts. *Journal of Affective Disorders* 136(1): 54–62.

Shannon, B.D., and V.R. Scarano. 2013. Incompetency to be executed: Continuing ethical challenges and time for a change in Texas. *Texas Tech Law Review* 45(2): 419–452.

Society of Correctional Physicians. 2013. Position statement: Restricted housing of mentally ill inmates. http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates. Accessed May 25, 2014.

United Nations.1966a. International covenant on civil and political rights. http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx. Accessed May 29, 2014.

———. 1966b. International covenant on economic, social and cultural rights. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx. Accessed May 29, 2014.

United Nations. 1977. Standard minimum rules for the treatment of prisoners. http://www.unodc.org/pdf/criminal_justice/UN_Standard_Minimum_Rules_for_the_Treatment_of_Prisoners.pdf. Accessed May 29, 2014.

United Nations. 1984. Convention against torture and other cruel, inhuman or degrading treatment or punishment. http://www1.umn.edu/humanrts/instree/h2catoc.htm. Accessed May 29, 2014.

United Nations Committee on Economic, Social and Cultural Rights. 2000. CESCR general comment no. 14: The right to the highest attainable standard of health (Art. 12 of the Covenant). Office of the High Commissioner for Human Rights, E/C.12/2000/4. http://www.refworld.org/docid/4538838d0.html. Accessed May 29, 2014.

United Nations Committee Against Torture. 2006. Consideration of reports submitted by States parties under Article 19 of the Convention: Conclusions and recommendations of the Committee Against Torture, United States of America, CAT/C/USA/CO/2. http://www.refworld.org/docid/453776c60.html. Accessed May 29, 2014.

United Nations General Assembly. 2011. Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, A/66/268. http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf. Accessed May 29, 2014.

United Nations Human Rights Committee. 1992. CCPR general comment no. 20: Article 7 (prohibition of torture, or other cruel, inhuman or degrading treatment or punishment). http://www.refworld.org/docid/453883fb0.html. Accessed May 29, 2014.

United Nations Human Rights Committee. 2006. Consideration of reports submitted by States parties under Article 40 of the Covenant: Concluding observations of the Human Rights Committee: United States of America, CCPR/C/USA/CO/3. http://www.refworld.org/docid/45c30bb20.html. Accessed May 29, 2014.

World Medical Association. 1997. Declaration of Hamburg concerning support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman or degrading treatment. http://www.wma.net/en/30publications/10policies/c19/index.html. Accessed May 29, 2014.

World Psychiatric Association. 1996. Madrid declaration on ethical standards for psychiatric practice. http://www.wpanet.org/detail.php?section_id=5&content_id=48. Accessed May 29, 2014.