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A Suicide at Rikers: Prison Health Services Takes Another Hit

The New York State Commission of Corrections, through its Medical Review Board, investigates and reports on deaths that occur in New York's prisons and jails. David Pennington committed suicide while in the custody of the New York City Department of Corrections. The Commission's Final Report on the matter, made available to us through a FOIL request, and its finding are instructive.

The Commission investigated and reported on the death by suicide of Mr. Pennington at New York City's sprawling Rikers Island. Prison Health Services (PHS), despite numerous problems with correctional health care services in upstate New York, and as further discussed in Fred Cohen, The New York Times Reports on Private Health Care: A Review, 7 CMH 69 (Jan/Feb 2006), landed the Rikers healthcare contract and then even obtained an extension.

The Death of David Pennington

Paul von Zielbauer's account of the suicide, New York Times, p.1 (April 4, 2005), tells the story succinctly:

> It was 2:50 p.m. on July 18, 2004, when David Pennington, a 27-year-old small-time thief in jail on a third-degree burglary charge, was sent from a clinic back to his cell at Rikers Island's largest jail. During the previous three days, jail doctors had

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Special Symposium Issue

The Role of Mental Health Professionals in Corrections

Editor's Introduction: *It may be somewhat inflated to label this feature a symposium issue. There are, however, four articles (or comments) of varying lengths related in varying ways to the issue of the correctional clinician's relationship to painful interrogation measures and the somewhat related issue of reporting abusive behavior by staff thought to be a contributing factor in an inmate-patient's mental illness.*

Obviously, there is much to distinguish participation in torture and knowledge of abuse by others that is contributory to suffering. It is the difference between active and passive except that remaining passive in the face of an obligation to act may be inculpatory.

The first article actually is a review of the powerful "Physicians' Torture Report." The Report concludes that psychological torture has become central to the U.S. military and intelligence interrogation process. A section entitled, "The Role of Health Professionals" is highlighted and serves as a springboard to examine the role of health professionals in our correctional systems.

The Cohen article then asks, "In our world of corrections, when a clinician comes to believe that the abusive behavior of an officer is contributing to an inmate-patient's mental illness, does the clinician file a report? Does he or she take other action designed to protect the inmate-patient? Is the clinician merely silent and perhaps hopeful that the situation will resolve itself?"

Joel Dvoskin, Ph.D. and Jeffrey Metzner, M.D. note that when staff violations become "boundary violations" that violate legal or ethical standards then there are a series of steps that must be taken. Silence is not an option.

The authors are leading professionals in the field as well as pragmatists and their discussion on how to handle correction officers' abuse is extremely valuable. Preven-

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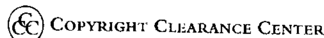

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tion of abuse is the desired first step, professionally dealing with it, the next.

Dr. James Knoll endorses the Cohen and Dvoskin/Metzner comments and focuses on the extraordinary burdens placed on correctional officers: protect, be wise, understand illness, be safe, be omnipotent. The correctional environment and the paramilitary-like organization of corrections staff pulls the correctional officer in conflicting directions.

Better training, better-educated staff, and an enhanced commitment to rehabilitation are on Dr. Knoll's wish list.

Dr. Terry Kupers chose to focus on the "ordinary abuses" in prisons; on the way inmates are addressed and on the way security staff "respect" inmates.

Security and treatment staff has different jobs to perform but with a mindset conducive to sharing different perspectives and solutions, needless tensions may dissolve.

Dr. Kupers offers some incisive analysis on the security-treatment ethical divide and also offers practical advice on cell extractions, penal isolation, and confidentiality.

Finally, this collection is consciously written in an informal and accessible fashion. I believe it is relevant, useful, and thought provoking.

We welcome readers' comments, particularly on the role of medical and mental health personnel working in U.S. prisons and jails. ■

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in some very dangerous drug practices and sexual activities. Still, the legal obligation to provide adequate care for serious illnesses and prevent suicide when there is good reason, as here, to suspect suicidality is clear.

PHS does not enter into medical care contracts, buy up competitors, and create a national pharmacy for its operations for, let us say, entirely altruistic reasons. Private companies that provide locum tenens physicians in California may receive $100,000 a year, and the physician $400,000 at the high hourly wages paid. That is not chump change.

PHS's revenues reportedly went from $110 million in 1994 to $690 million in 2004. Its stock in February 2005 closed at $27.64 a share from a split-adjusted price of $3.33.

In the old days of the war on poverty, it used to be said that there is money in poverty. How might we restate that for the role of some private providers in correctional health care? ■

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The Physicians' Torture Report: A Review

by Fred Cohen

There are a number of good reasons to carefully read the Physicians for Human Rights126-page report entitled, *Break Them Down: Systematic Use of Psychological Torture by U.S. Forces* (2005). This is the first comprehensive examination of the use of psychological torture by U.S. personnel in this era of the "war on terror."

The inherent difficulties of preparing such a report are compounded by an administration noted for its secrecy and its commitment to the use of military aggression commensurate with its views on the nature of the threat posed by international terrorism. I should note, however, the semantic shift with regard to Iraq where insurgency has replaced terrorism. Terrorism is now a proxy for the international battle while insurgency appears limited to Iraq. Does it then follow logically that the most drastic measures are appropriate for the larger threat? Probably. Does it also follow as a matter of policy? Probably not.

The Report under discussion reviews interrogation techniques used on detainees, the evidence of long-lasting and devastating health consequences of psychological torture, how the United State's regime of psychological torture emerged and was perpetuated, and the current status of psychological torture in U.S. policy. While the evidence is far from complete, the Report concludes that psychological torture has become central to the military and intelligence interrogation process and is reinforced by a variety of abhorrent conditions of confinement.

If we view interrogation as a process designed to obtain information pertaining to individuals' guilt or for use as intelligence against those who are in some fashion a threat, then this Report is of little direct relevance to American corrections. Police interrogation techniques in this country are employed early in the criminal process, nearly always in the stationhouse, and the most dubious of those processes amount to role playing (the Mutt and Jeff routine); lying about an accomplice or the harm to a victim; making promises that will not be kept, and the like. The era of whacking a suspect about, protracted interrogations without sleep or food, and the tin box in the sun have virtually disappeared in the Untied States primarily because of judicial implementation of Due Process, Fifth Amendment, and Sixth Amendment rights.

The **Miranda** warnings and potential for early involvement of counsel along with reasonably protective rules on involuntary confessions (was the will overborne?) have created a set of conditions reasonably protective of the use of force on an arrestee or detainee. On the other hand, duplicity and fraud, in some circumstances, is constitutionally protected.

Once an individual has been convicted and sentenced to prison, the use of psychological terror to obtain information is virtually nil. Indeed, it is the use of prolonged, penal isolation to obtain behavioral compliance, not information, that is subject to the most rancorous debate. See Craig Haney, *Reforming Punishment: Psychological Limits to the Pains of Imprisonment* (2005), for a detailed exploration of these issues.

The Report is of obvious relevance to us simply as citizens and as persons who seek to be informed about practices that have produced worldwide shock. That shock, in my view, is not because U.S. practices are unique in the world. Rather, it is precisely because it is the U.S. Military pictured at Abu Ghraib; the snarling dogs, the pyramids of naked Muslim captives, the hooded detainee "wired" for electrocution, and the smiling, female soldier mockingly pointing at captives' genitalia. Those images, and the subsequent revelations discussed in the Report, form indelible images of "us."

On the other hand, reporter Sasha Abramsky interviewing residents of Waynesburg, PA., home of convicted soldier Charles Graner, Jr. of Abu Ghraib notoriety, reported that residents complained much more over the publication of the Abu Ghraib pictures than the conduct itself. Graner, of course, had worked as an officer at SCI-Greene, a tough supermax housing Black, Muslim inmates. See Seeds of Abu Ghraib, The Nation, p. 20 (Dec. 26, 2005).

Beyond our concern as citizens, there is our role as the American System of Criminal Justice. Most readers of this publication are likely to be in some sense connected with corrections whether as scholar, lawyer, clinician, uniformed officer, or ranking official. The direct lessons from this Report for corrections lie at the outer perimeter of our legitimate concerns.

For example, the Report notes:

> In late 2003, the ICRC warned the Administration publicly that a system in which detainees were held indefinitely would inevitably lead to mental health problems. When the ICRC visited Guantánamo in June 2004, it found a high incidence of mental illness produced by stress, much of it caused by prolonged solitary confinement. A source familiar with conditions at Guantánamo at that time told PHR that deprivation of sensory stimulation on the one hand and overstimulation on the other were causing spatial and temporal disorientation in detainees. The results were self-harm and suicide attempts. Report at p. 10 (citations omitted, ICRC is the International Committee of the Red Cross)

Applied to long-term use of penal isolation or the most restrictive of our supermax prisons, the point is of obvious interest.

There is, of course, a lively debate about virtually everything discussed in the Report. There is the "isolated incident" crowd that views Abu Ghraib, for example, as both overblown and hardly characteristic of U.S. practices. Others accept the reports of abuse but use a variation of the "Dirty Harry" scenario to justify the practices given the perceived imminence and seriousness of the threat. Still others, as in Waynesburg, PA, accept the abuse but decry the publication.

On the other side, there are moralists-legalists who argue that the false execution, waterboarding, dogs, sleep deprivation, and sexual humiliation are morally abhorrent and violative of international and domestic law. Then, there are the realists who argue that information obtained under the conditions described in the Report is nearly always useless. Further, there is the "you do me and I'll do you" school of realism that worries less about misinformation than retaliation. Senator McCain appears to adopt both the "useless" and "rehabilitation avoidance" positions.

One way to test one's position on torture is to ask: Suppose the more painful and threatening interrogation techniques described actually were reasonably productive of useful information; information that could save American lives? Would you support,

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say, near drowning, beatings, or food and sleep deprivation? Remember, pre-**Miranda** confessions often were reliable v. the coerced confessions, which were not.

Listening to the charges brought against Saddam Hussein in the early days of his trial, one heard a female victim's voice coming from behind a protective screen saying she was stripped naked, sexually humiliated, held for a prolonged period of time, and I think, beaten. Sound familiar? This, of course, is part of a trial where the accused faces the death sentence.

There is another angle to the Report that should interest readers who are psychiatrists, psychologists, or associated with other helping professions. In a section entitled, "The Role of Health Professionals," the participation of health care professionals in interrogation is described:

> Health personnel employed by the Department of Defense and other agencies in the "war on terror" are bound by international law. In addition, they should abide by ethical standards of the World Medical Association and the American Medical Association. The Declaration of Tokyo, adopted by both bodies, prohibits participation of physicians in torture and all forms of cruel, inhuman, and degrading treatment. This includes providing "knowledge" to "facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment." It also prohibits the physician's presence when any of these practices takes place. This has been interpreted to prohibit examinations prior to or after interrogation because such examinations involve health personnel in calibrating coercive or unlawful techniques of interrogation. The UN Principles of Medical Ethics provide similar guidelines for health personnel charged with the medical care of prisoners and detainees.
>
> There is evidence, however, of failure on the part of health professionals to report acts of abuse as well as evidence of health professional complicity in acts of physical and psychological torture. As with incidences of psychological torture, the picture is incomplete and more investigation is needed. There is some evidence that medical personnel were aware of abuse but failed to report it. The Fay report cited some medical corps personnel for observing and failing to report instances of abuse at Abu Ghraib. The Fay report recommended an inquiry into whether medical personnel were aware of detainee abuse and failed to properly document and report the abuse.
>
> There is evidence that interrogators had direct access to detainees' medical files. The ICRC raised concerns about this with Maj. Gen. Miller in an October 2003 meeting about treatment of detainees at Guantánamo. In the meeting, ICRC representatives told Maj. Gen. Miller that "medical files are being used by interrogators to gain information in developing an interrogation plan." They expressed concern that "there is a link between the interrogation team and the medical team." The ICRC called this a "breach of confidentiality between a physician and a patient" and explained to Maj. Gen. Miller that "[o]nly medical personnel are supposed to have access to these files." In a leaked report based on visits in June 2004, the ICRC said that medical files of detainees were "literally open" to interrogators. A source with knowledge of operations at Guantánamo confirmed to PHR that confidentiality was openly disregarded by many members of the US medical staff there, and that this was due to an order "from the top."
>
> There is evidence that in addition to sharing medical records, health professionals participated more directly in interrogations. This is not surprising, given that the April 16, 2003 memo by Secretary Rumsfeld explained that interrogation techniques at Guantánamo were to be used only after detainees are "medically . . . evaluated as suitable." This reliance on medical evaluation and approval appears repeatedly in the guidance and directives. For example, it appeared in memorandums governing interrogations in Iraq as well. A January 27, 2004 memorandum for Iraq specifies that dietary manipulation, sleep management, and sensory deprivation all must be "monitored by medics."
>
> Col. Thomas M. Pappas, the head of military intelligence at Abu Ghraib, described to General Taguba how that worked in practice:
>
> If the interrogation plan falls within the outline set by LTG Sanchez then the O5 Deputy Director or myself approve the plans. Those interrogation plans include a sleep plan and medical standards. A physician and a psychiatrist are on hand to monitor what we are doing. . . .
>
> Typically, the MP has a copy of the interrogation plan and a written note as to how to execute. There should also be files in the detainee files as to what is going on when an exception is needed. The interrogator uses these files to keep a record as to what has happened to the detainee. The doctor and psychiatrist also look at the files to see what the interrogation plan recommends; they have the final say as to what is implemented.
>
> At Abu Ghraib and Guantánamo, "behavioral science consultation teams" (hereinafter BSCT), composed of psychologists and psychiatrists, were formed with the purpose of facilitating interrogation. A source knowledgeable with BSCT's functioning at Guantánamo told PHR that interrogators and heads of medical staff met with BSCT in order to discuss detainees' medical conditions that may cause problems during interrogations. But interrogators did not go through BSCT in all cases; interrogators were able to go directly to medical staff without going through BSCT members. In its leaked report, the ICRC complained to the US about BSCT and the fact that doctors and medical personnel conveyed information about detainees' mental health and vulnerabilities directly to interrogators. Evidently, interrogators found this approach effective. One e-mail about Guantánamo made available through the FOIA lawsuit says, "I've met with the BISC (Biscuit) people several times and found them to be a great resource. They know everything that's going on with each detainee, who they're talking to, who the leaders are, etc. I've encouraged the interview teams to meet with them prior to doing their interviews."
>
> These arrangements compromised the care of detainees at Guantánamo. A source told PHR that detainees refused to discuss their psychiatric problems with US physicians because they knew that the information was passed on to interrogators, who could then use it against them during interrogations. It also dam-

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aged the relationship between doctors and detainees. Many detainees were convinced that their health care was actually controlled by interrogators and did not believe the doctors' claim that they were there for the benefit of the detainee. In a report to the US government based on a June 2004 visit to the naval base, the ICRC pointed out these problems to the US government. It called what was happening at Guantánamo a "flagrant violation of medical ethics." Report at pp. 45-47(citations omitted)

The failure to report abuse, facilitation of abuse, sharing of medical records, monitoring abusive practices and the like must, at a minimum, be subject to professional condemnation. In our world of corrections when a clinician comes to believe that the abusive behavior of an officer is contributing to an inmate-patient's mental illness, does the clinician file a report? Does he or she take other action designed to protect the inmate-patient? Is the clinician merely silent and perhaps hopeful that the situation will resolve itself?

Barrister Jonathan H. Marks, The Silence of the Doctors, The Nation, p. 26 (Dec. 26, 2005), condemns the involvement of doctors and psychologists in the interrogation-torture process. The American Psychiatric Association has taken a strong stand against advising on deceptive interrogation techniques while the American Medical Association is cautiously silent and the American Psychological Association cautiously cooperative; that is, relying on the government's position as to torture and tough interrogation practices.

I have not tried to summarize the Report, merely to address some of the issues at a right angle. The material on the legal framework is excellent as is the detailed discussion of the prevalence and consequences of the various interrogation-torture techniques employed by the United States.

As this is written, there is some hope that Senator McCain's campaign for a "no torture" law may be accepted by the Administration, which continues either to deny the charges or rely on the "few bad apples" argument.

Ultimately, each of us will decide for ourselves how we assess the moral, legal, and practical acceptability of the practices described. As citizens we need to know, as professionals in corrections we need to care.

See, The Torture Debate in America (ed. Karen J. Greenburg)(Cambridge Univ. Press 2005); Torture: Does it Make us Safer? Is it Ever O.K.? (eds. Kenneth Roth & Minky Worden)(The New Press 2005); and, The Nation, "The Torture Complex: Special Issue," (Dec. 26, 2005). ■

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ety of emotions on the inmates in their charge. Explicit examples were recently given when correctional officers testified at the *Commission on Safety and Abuse in America's Prisons* in 2005. A veteran officer described abuses and hinted at one type of perverse outcome:

> The Segregation Unit was directly above Protective Custody, and it was there that some of the worst abuses took place. Sleep deprivation was a common tactic among the more sadistic guards assigned to the unit, and they often bragged about the mistreatment they dealt out daily and nightly. I often heard the beatings and screams for help coming through the air vents we shared, dispensing recycled and filthy air along with pleas for mercy.
>
> ...One inmate once said to me... 'they're making monsters in here, and I'm one of them; when I get out, they'll reap what they've sown.'[5]

To summarize, we know that officers are critical to the rehabilitation of inmates. We also know that powerful emotional forces are at play, especially where efforts at rehabilitation are concerned. Finally, we appear to expect officers to possess super human abilities to carry out the goals of rehabilitation. All of this leaves one to wonder — when will it be time to re-examine the selection, training and roles of the correctional officer? Returning to the Commission testimony, a warden of a maximum-security prison began to address the issue:

> Better pay, better training and better-educated staff are a good beginning. In the final analysis, however, without strong leadership at the top, without a demand for professional excellence, the levels of violence in America's prisons will continue to be a significant problem.[6]

Such "professional excellence" would be well placed in the form of a new breed of corrections staff who are equipped with the proper tools such as better training in the social sciences, meaningful support and supervision and a clear agenda from leaders that emphasizes human dignity and pays homage to the delicate and difficult work that they do. In corrections, the "line" correctional officer is easily the most precious commodity we have. I have worked with many officers who do possess an amazing array of skills and abilities. They are easy to spot — they are the ones everyone enjoys working around.

However, it still seems unreasonable to me that so much is expected of today's correctional officers, yet so little attention is paid to the challenges they face and the training they receive. Perhaps it is unreasonable to expect so much from a single individual. For example, in a psychiatric facility, the job of psychiatric technician and security officer are two different jobs. Staff and patients rarely interact with security officers unless it is to protect a patient from harming himself or others. The roles are kept distinct, and no one expects the security officer to adopt a confusing therapeutic-like relationship with a patient.

To be clear, I am not suggesting that correctional facilities need less security personnel. A climate of violence, fear and disorder would obviously preclude meaningful efforts at inmate programming. There must necessarily exist an adequate level of institutional safety. What I am left to ponder is whether it is reasonable to expect a single individual to uphold not only the heavy burden of security, but also the lofty aspiration of rehabilitation?

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Commentary: The Physicians' Torture Report

by Joel A. Dvoskin, Ph.D., ABPP, and Jeffrey L. Metzner, M.D.

Professor Cohen's review of the Physicians for Human Rights 126-page report entitled, *Break Them Down: Systematic Use of Psychological Torture by U.S. Forces* (2005), highlights issues relevant to correctional mental health staff.

We agree that the focus on interrogation as a process designed to obtain information pertaining to individuals' guilt or for use as intelligence against those who pose a threat, although very important from a human rights perspective, is of little direct relevance to American corrections.

The direct lessons from this Report for corrections, as summarized by Professor Cohen, involve basic standard of care issues, conditions of confinement concerns, and questions concerning staff responses to staff misbehavior in jails and prisons. This article will attempt to address these important issues.

The Report detailed violations of the standard of care, including sharing of medical records for non-health related reasons (i.e., interrogation/torture), and boundary violations. For many different reasons, almost always including resource issues, standard of care violations have occurred in a significant number of correctional systems as evidenced by successful class action suits (Metzner, 2002). What should correctional health staff do in such circumstances?

In a correctional environment, the importance of maintaining the confidentiality of medical records, with some specified and explicit exceptions, is well established by national standards and guidelines (National Commission on Correctional Health Care 2003, 2003a; American Psychiatric Association 2000). Correctional health care professionals, including mental health professionals (MHPs), should be very sensitive about this standard, advocate for effective implementation, and resist attempts to chip away at this principle. For example, some correctional systems have placed certain mental health treatment records in the correctional classification record, without obtaining informed consent from the inmate. One state correctional system attempted to allow the internal affairs section access to health care records of inmates who were making sexual harassment allegations against correctional staff. Such access was prevented because the director of mental health services took the proper administrative and advocacy steps that resulted in rejection of such a policy and/or practice.

Dual agency issues in correctional mental health care exist, but are manageable if they are appropriately disclosed and do not result in harm to the inmate-patient/client. However, when they become boundary violations that violate legal or ethical standards, or cause unnecessary harm to an inmate, the standard of care is violated. NCCHC standards are clear that information obtained as a result of health care treatment should not typically be used for forensic purposes and that health care personnel should not participate in procedures that are harmful to inmates, especially direct implementation of the death penalty (e.g., inserting the intravenous line for a lethal injection). If health care staff become aware of such practices, they would be expected to take appropriate action, which may include talking directly to the health care professional, appropriate supervisory response, reporting the person to the appropriate supervisor, filing an ethical complaint, reporting to the appropriate licensure board, etc. Depending on the health care professional's licensure and/or professional organizational affiliations, reporting in some fashion may be legally and/or ethically required.

Several issues raised in the Report are relevant to supermax prisons. The NCCHC standards (Metzner 2003) and APA taskforce guidelines have recognized health care issues inherent in such settings, such as restricted access to health care services and potential adverse consequences for inmates with serious mental illness due to the conditions of confinement. MHPs should advocate for implementation of these guidelines and recommendations within their correctional workplace and be alert to other conditions of confinement that negatively affect the health of inmates.

The above scenarios are generally less difficult for mental health care professionals to navigate than abuse by correctional staff. Professor Cohen raises the more difficult scenario — when a clinician comes to believe that the abusive behavior of a correctional officer is contributing to an inmate-patient's mental illness, does the clinician file a report? Does he or she take other action designed to protect the inmate-patient? Is the clinician merely silent and perhaps hopeful that the situation will resolve itself?

For mental health professionals working in correctional environments, this raises especially difficult questions about moral, ethical, and legal obligations, as well as practical concerns. In some ways, these dilemmas are no different from the unwritten rules that govern the willingness of police officers, physicians, union members, and a host of other formal and informal groups to tell the truth when they become aware of misbehavior. The so-called "blue wall of silence," where it exists, is based on the stern principle that police officers always and without exception "protect their own."

Various police and correctional agencies have fought the blue wall of silence for a long time, frequently to little avail. It is dangerous to be deemed a traitor by the people on whom you depend to protect your life, to "cover your back." Good and ethical officers reasonably fear that if they inform on other officers who misbehave, not only their standing among their peers but their physical safety will be in danger.

Since only a small percentage of officers are ever even accused of serious misbehavior, it is worth asking why most police or correctional officers, who try hard to play by the rules, would endorse such a self-defeating policy. The answer may lie in the difficulties inherent in any law enforcement or correctional job. It is unlikely that any officer can say with confidence that they will never, in the heat of the moment, respond to a reasonable fear unreasonably. To the extent that they believe that they will be judged harshly, rigidly, and unfairly, each of them fears that they might one day become a potential "abuser."

It goes without saying that these same concerns apply to mental health professionals who work in correctional settings. Despite the fact that mental health care is a constitutionally required and routine part of any correctional system, it remains true that many correctional mental health professionals are treated, or consider themselves, to be visitors in the world of another profession. We are supposed to learn and follow their rules, both formal and informal. Most of these rules, of course, especially those that are written and formal, are ser-

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sible and designed to protect us, and we violate them at our own peril and the peril of others. But what about the unwritten rules, especially the ones that require our silence in the face of wrongdoing?

It is easy to advise correctional mental health professionals to always "do the right thing" and report every transgression. But such advice would be unrealistic and not particularly helpful, as anyone who followed it would have a difficult time remaining in the field. On the other hand, a willingness to remain silent in the face of wrongdoing, even if minor at first, runs the risk of providing a slippery slope toward the worst kinds of abuses. Examples of minor abuses include verbal harassment of mentally ill inmates (e.g., calling them "bugs" or belittling an inmate's need for antipsychotic medications). Serious abuse would include physical beatings or "set-ups" that allow an inmate to be attacked by other inmates.

How, then, can a MHP remain ethical, moral, and legal in their behavior, without alienating the correctional staff? We have some suggestions that might prove useful.

Regarding "minor" abuse and/or inappropriate correctional staff interactions with mentally ill inmates, direct discussion with the correctional staff regarding the MHP's concerns can be helpful. Such a discussion should include suggestions for alternate ways of interacting with the inmate that will accomplish desired reasonable outcomes. Discussions with the correctional officer's supervisor or the MHP's supervisor are other options, depending on the circumstances.

Major staff misconduct is a more difficult issue, especially when use of force is involved. The MHP should keep in mind that some staff behavior may have appeared inappropriate when, in fact, it represented a necessary use of force. Reporting abuse in such a circumstance serves no purpose, and likely alienates the reporter unnecessarily. The way to avoid these situations is for mental health professionals to acknowledge that their own responsibility for institutional security is no less than that of security and custody staff. While our contributions to institutional safety are different than theirs, they are no less important. Further, we should manifest this belief with behavior, by taking the time to learn as much as possible about the rules and methods regarding institutional discipline, especially when force is required.

An easy way to be alienated from correctional staff is to betray them. If they believe that a clinician is willing to be complicit in covering up abuse, they will respond much more vehemently to a report. To avoid this situation, mental health professionals need to establish their integrity early and unambiguously. This is best done by cleaning up one's own house (i.e., mental health services) as referenced previously. This involves not simply the more obvious standard of care scenarios summarized earlier, but demonstrating to custody staff integrity, straight-forwardness, and conscientiousness in performing their mental health care roles. For example, when a correctional officer makes a mental health referral, mental health staff should provide feedback to the officer, especially positive feedback if the referral was helpful. Responses to such referrals should be timely and competent. It is hypocritical to criticize the performance of a correctional officer if our own standards of professional and ethical behavior are lax.

It is common for correctional staff to respond to inmate misbehaviors with negative reinforcements that are often unhelpful and may lead to abusive responses by both inmates and custody staff. Helping the staff develop more effective interventions results in benefits to both inmates and staff and facilitates awareness by both inmates and custody staff of the clinician's integrity and commitment to their health care role. During this process, the clinician has various opportunities to discuss with correctional staff interventions that would be helpful as well as those that would be inappropriate and abusive. The clinician should make clear during such discussions his/her responsibility to take appropriate steps if abusive interventions occur. This is one way of clearly placing correctional staff on notice that serious misbehavior will not be ignored or covered up. Such a discussion simultaneously establishes the integrity of the mental health clinician, as well as his or her willingness to be a dependable teammate in times of peril.

Working with correctional staff in developing policies and procedures relevant to calculated use of force, especially when it involves inmates on the mental health caseload, is another way of decreasing abusive behaviors by correctional staff. Such policies usually require an attempted intervention by health care staff, preferably mental health staff, prior to the use of force. These practices can be effective in decreasing use of force and in helping correctional officers to learn better verbal interventions. At the same time, it improves the working relationship between mental health clinicians and their custody colleagues.

Implementation of such policies and procedures educates the mental health clinicians about situations where the necessity for force was legitimate but not obvious. It also allows the mental health clinician to educate the correctional staff to consider alternatives to the use of force. Keep in mind that the vast majority of abuse is an emotional response — often fear and anger — to some form of inmate behavior. As experts in human behavior and emotion, who better to suggest alternatives than mental health professionals? Finally, this process allows mental health clinicians to offer prospective assistance as an alternative to the use of force.

A decision to report misbehavior is also differentially viewed by custody staff, depending upon their general assessment of the mental health clinician. One can build a safety net of trust by rapidly and clearly coming to the defense of an officer whose apparent misuse of force was in fact justified and necessary in the face of a threatening situation: "I was there, Captain, and observed the entire situation. Officer Jones made several attempts to verbally de-escalate the situation, and invited me to help. Neither of us was able to succeed, and I agree with Officer Jones' assessment that the inmate posed an immediate threat to his safety." This same declaration should be made in writing. Officer Jones and the entire employee "grapevine" will take note that the mental health clinician "stood up" for a colleague, which is a reference to integrity and dependability. Similarly, when officers behave in especially positive ways, a letter of thanks to the officer's supervisor will demonstrate that the MHP is as willing to praise as to criticize.

Integrity enhances the standing of a mental health clinician in a correctional environment, so long as it goes both ways. Being a "stand-up" person cannot only mean defending staff behavior when it is justified; it must also mean reporting it when it is not. People who appear willing to "go along to get along" create a reasonable expectation that they will lie to defend a colleague, and if they fail to do so, they will be viewed as traitors. On the other hand, people who make their integrity known, and who are willing to learn about the realities on jail and prison from the perspective of officers, can actually prevent misbehavior by their very presence on the scene.

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be punished, or he needs to be isolated from others for security reasons.

I will mention two other instances where treatment and security needs often clash. Ethical standards for mental health professionals mandate confidentiality when a patient reports an event such as a rape, the clinician is not to report the crime but rather is required to review with the patient his or her options and the possible ramifications of reporting or not reporting — the choice to report is left to the patient. In many corrections systems all staff are required to report any crime they hear about, and this security requirement supposedly trumps the ethical requirement of confidentiality. But should it? There are serious ramifications in a corrections system when a prisoner reports being the victim of rape, and it is often not the case that security staff can guarantee safety to the individual doing the reporting. Mental health clinicians have an ethical obligation to counter automatic reporting requirements by advocating for the mental health needs of their patients, including their patients' right to confidentiality and choice. The other instance involves disciplinary reports for non-compliance with medications. Compliance is a clinical issue, and one clinician's address in every setting where they treat individuals suffering from serious mental illness. Criminalizing non-compliance (i.e., writing a ticket for medication refusal) is contrary to treatment and ethical standards in the mental health professions.

In many of the lawsuits where I serve as an expert witness, a major complaint lodged by the prisoner class is that many individuals subjected to long-term punitive segregation or isolated confinement suffer psychiatric breakdowns in isolation, and they need to be removed from segregation and transferred to a mental health treatment unit. Clinicians diagnose psychosis, and we know that isolation often causes breakdowns and more disruptive behavior in people prone to psychosis. Security staff might counter that the prisoner in question is very assaultive and it is too dangerous to remove him from segregation. Both sides in this classic dispute are doing their jobs. The treatment needs require exclusion from segregation and participation in a treatment program; the security needs include restraint and isolation. We need to talk. (Note: the Physicians for Human Rights report on torture explores in depth the known toxic effects of isolation – but that is a subject for another discussion.) Too often, the mental health staff cede their authority to security staff, or security staff demand they act more as "team players," and there is no real discussion of the pros and cons of isolating disturbed/disruptive prisoners. What if the differing staffs could talk freely with each other about the issue? What if mental health staff could stop worrying that security staff might consider them disloyal if they advocate too strenuously for treatment needs? What if security staff could rely on the judgment of mental health staff and work more collaboratively to construct a plan that permits the prisoner to be placed in a setting where security and treatment needs can both be addressed?

I am arguing for a culture of prison work that permits more open and frank discussion about the ordinary abuses that regularly occur in prison. That could be the positive upshot of the PHR report on American corrections. It might be a matter of a sexist comment to a woman prisoner; it might be a matter of an unnecessary cell extraction. Only if the culture permits open discussion can the staff member who observes the abusive statement or act talk informally and without reprisal to the staff member responsible for the instance of ordinary abuse. Currently, it is my impression that staff, on average (there are many admirable exceptions), are too cowed by the unstated loyalty or "blue code" requirement to engage in much open discussion. This simple proposition would not in itself put an end to human rights abuses in correctional settings, but it could pave the way toward the creation of a culture of prison work where there is zero tolerance for abusive treatment, whether the abuse is large and unconstitutional (i.e., torture by international standards) or small and ordinary. ■

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This last point deserves some discussion. Officers protest, "I put my life at risk on a daily basis, and you expect me to keep you safe. Then you turn around and accuse me of abuse?" Mental health clinicians must be willing to bend, to be moral instead of moralistic. They must be willing to hear both sides of the story, before leaping to a conclusion at the expense of an officer. They must be willing to do what they reasonably can to assist an officer in trouble. A strong young MHP might jump in to help save an officer, while a frail, elderly MHP might race, as quickly as they can, to a phone to call for help. Every MHP can take the time to attend security training. In our opinion, it is a valuable experience and excellent investment of time for MHPs to attend the correctional officer academy before beginning their first correctional job. To do so informs the institution that this is one MHP who understands that he or she has a lot to learn about this dangerous and stressful environment.

All of this being said, despite our best efforts to prevent staff misbehavior, it will occasionally occur. We would be remiss if we ignored the important question of how to report abuse or serious staff misbehavior. First, take time to be certain of your facts. There is no greater mistake than making a serious accusation that is factually incorrect. Second, if possible, it is not a bad idea to get a confidential second opinion from a custody/security person. Even if your "consultant" is unwilling to step forward, he or she may be able to give you information that supports or revises your opinion about what happened. Third, it is imperative that the allegation is made in writing, to protect you from being misquoted or misrepresented. (And of course, keep a copy in a safe place.) If an inmate makes an allegation of abuse, it may come to court years after the alleged events took place; relying on your memory is a very bad idea.

As is the case with so many ethical dilemmas, the best course is to avoid them in the first place. It is difficult to betray a promise that was never made or implied in the first place. By establishing one's character as ethical, moral, and dependable, it is possible to be a valued teammate without silently tolerating staff abuse or misconduct. In correctional facilities, an ounce of prevention is truly worth a pound of cure.

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