

# Dual Agency and Ethics Conflicts in Correctional Practice: Sources and Solutions

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Psychiatrists working in corrections, particularly in areas that have a shortage of forensic practitioners, may encounter a variety of ethics-related conflicts, especially when working both as clinicians and forensic evaluators within smaller systems. Such conflicts may include unavoidable dual treating and forensic evaluator relationships, and awareness of information that may complicate patient treatment or influence forensic opinions. Additional conflicts may arise if the psychiatrist is also retained privately to conduct forensic evaluations involving inmates in the same facility or facilities where the psychiatrist is otherwise employed, specifically because he may have duties to both a retaining party and an employer. Early-career psychiatrists, those who are completing their training in forensic psychiatry, and general psychiatrists who practice in corrections may be unfamiliar with the ethics-related dilemmas that arise in jails or prisons. Ethics courses during medical school and residency, while required, rarely discuss dilemmas specific to correctional settings. Furthermore, many psychiatrists practicing in corrections do not undergo formal training in forensic psychiatry, and even among different fellowship programs, the amount of time devoted to corrections varies significantly. The authors discuss hypothetical cases that reflect situations encountered, particularly by psychiatric fellows, forensic psychiatrists new to correctional work, and nonforensic clinicians working in corrections, a setting where dual agency is common and at times in conflict with core principles of ethics, including beneficence, nonmaleficence, neutrality, objectivity, and justice.

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Psychiatrists working in corrections, particularly in smaller systems, where there may be a limited number of providers, may find themselves simultaneously assuming a treatment role and the role of a forensic evaluator. Psychiatrists who assume care of an inmate, for purposes of treatment, are expected to act in the inmate's best interests, whereas forensic evaluators serve the interests of the judicial system. It is now a well-established and widely accepted principle that acting in dual roles (as a forensic evaluator and a treatment provider) for the same individual is not advisable and can lead to ethics-based conflicts.<sup>1–5</sup> Although there may be some advantages to having an evaluator assume both roles for the same individual from an efficiency standpoint, there are significant problems, including difficulty remaining objective and potential damage to a treatment relationship.

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On the one hand, a treatment relationship invokes the duty to act in the best interest of the patient (beneficence) and to do no harm (nonmaleficence), whereas the central responsibility of a forensic evaluator is to justice, not to the patient,<sup>3,4</sup> and requires adherence to core principles of neutrality and objectivity. While education in medical ethics is provided during medical school and residency, it does not always address conflicts specific to forensic psychiatry and more specifically to corrections. Psychiatrists who complete a forensic psychiatry fellowship will have minimal exposure (usually a six-month correctional rotation, that can occur in jails and prisons). However, a course in medical ethics will almost certainly not provide complete exposure to all the conflicts that may arise in correctional settings, especially if the exposure occurs exclusively in a prison setting, where pretrial concerns are usually not dealt with.

The Accreditation Council for Graduate Medical Education (ACGME) requires general (and forensic) psychiatry training programs to address certain core competencies, including:

(IV.A.2.e) Professionalism: Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles [Ref. 6].

The American Board of Psychiatry and Neurology (ABPN) now requires certain core competencies for board certification and maintenance of certification in general psychiatry and in the subspecialty of forensic psychiatry. A psychiatrist must be able to demonstrate responsible patient care and ethical behavior, with an emphasis on integrity, honesty, compassion, confidentiality, informed assent or consent, professional conduct, and conflict of interest.<sup>7,8</sup>

Certification in forensic psychiatry also requires fulfilling a core competency of “application of ethical principles in delivering medical and forensic services,” and “demonstrat[ing] understanding of the Legal Regulation of Psychiatry, which includes Ethics, including Research Ethics,” and under Professionalism Core Competencies, “The application of ethical principles in delivering medical and forensic services.”<sup>8</sup>

Organizations devoted to correctional health care, such as the National Commission on Correctional Health Care (NCCCHC) and the American Correctional Health Services Association (ACHSA), as well as the American Academy of Psychiatry and the Law (AAPL) and the American Bar Association (ABA) provide some guidance on ethics in regard to treatment and evaluation in jail settings and on management of forensic information.<sup>9-12</sup> We will provide recommendations and solutions to decrease or eliminate ethics-associated conflicts regarding the assumption of both a treatment and forensic evaluator role in correctional settings.

We present two hypothetical cases that explore the problem of dual agency in corrections followed by an analysis of the conflicts presented in each case; references to available guidelines, where these may be applicable; and, in conclusion, a discussion of the rationale for recommended actions that minimize or eliminate the ethics-related problems associated with dual agency.

### Case 1

A psychiatrist working in a jail began treating an inmate who was charged with a serious assault for allegedly injuring his girlfriend. Upon arrival at the jail, the inmate was described as highly emotional and was threatening suicide. He had several felony convictions and was concerned about receiving a life

sentence for his current charges. Staff verified that before his incarceration, he had been treated with an antidepressant prescribed by a primary care physician. The inmate acknowledged a history of heavy alcohol use. He was placed on constant observation and a short alcohol detoxification protocol; a psychiatric consultation was requested for medication management and for the appropriate level of observation. The psychiatrist evaluated the inmate two days after his arrest and found him to be extremely distraught and emotional, tearfully insisting on describing in some detail the actions that led up to his arrest, which the psychiatrist documented as, “Patient reports he stabbed his girlfriend in the arms and face because he was angry and intoxicated on alcohol and cocaine. He reports that he had discovered several months ago that his girlfriend was cheating on him and stealing money from him and that it all came to a head that night.” The inmate added that he hoped that she would be “so messed up that no one would want to be with her again.” The psychiatrist requested more details regarding the amount of alcohol and other drugs consumed for purposes of determining whether the initial detoxification protocol was appropriate. The inmate reported drinking 12 beers plus using cocaine on the night of the offense. He also reported that he had been prescribed an antidepressant approximately one year ago, when he became depressed, lost his job, and attempted suicide by hanging. The inmate continued to talk about the offense, seeking to justify his actions. He was very worried that, if he were found guilty, he would receive life in prison and stated that he has “not been able to sleep at all.” He denied any remorse, and insisted that he felt hopeless and suicidal; however, the corrections officer watching the inmate reported that the inmate had been smiling, laughing, and making telephone calls to what appeared to be at least one girlfriend.

The psychiatrist maintained the inmate on constant observation and continued the antidepressant and the alcohol detoxification protocol, documenting the history of alcohol and drug use, and noting that the last use of alcohol was reported to be on the night that the alleged offense occurred. The inmate was seen for follow-up by the psychiatrist the following week. He was no longer receiving detoxification medications and was compliant with his antidepressant. He remained on constant observation because he was reporting thoughts of wanting to hurt him-

self; however, he was significantly calmer and stated that he believed that his girlfriend would not testify against him. He was hopeful that the charges against him would be dropped or reduced and that he might receive probation. He also told a forensic counselor that he preferred the constant-observation area, because it was quieter and he could sleep better than in general population. The psychiatrist documented that the inmate was “presenting as somewhat manipulative,” but kept him on constant observation and the antidepressant.

The following week, the psychiatrist received a request to provide an opinion to the court as to the inmate’s competency to stand trial and criminal responsibility, based on the inmate’s entering a plea of extreme emotional disturbance. Because the other two psychiatrists were unavailable, the inmate’s care was to be transferred to a nurse practitioner, who would continue his medications, and the psychiatrist would have to perform the forensic evaluation for the court to receive it in time for the next hearing date. The psychiatrist reluctantly agreed.

When the psychiatrist met with the inmate for the evaluation, he informed the inmate that the conversation was not confidential and that a report would be submitted to the court. The inmate was asked to provide his version of events for purposes of determining whether he was able to disclose relevant information to an attorney and to testify relevantly if he chose to do so. The inmate provided a different version of events and denied using any drugs or alcohol on the day of the offense. He reported being extremely angry at his girlfriend after finding out about her having an affair and stealing from him, but also reported that some of the knife injuries on his girlfriend were self-inflicted. The inmate did not appear to remember that he had given a different version of events before this contact. The psychiatrist deemed the inmate competent to proceed with the adjudication process and opined that he would not meet criteria for extreme emotional disturbance, mentioning the prior contacts with the patient as a source of information.

The defense attorney for the inmate subpoenaed the record, and later, the psychiatrist. The defense attorney challenged the information that the psychiatrist relied on from the first two contacts with the inmate, arguing that the psychiatrist inappropriately assumed a dual role as both treater and evaluator. The attorney challenged the psychiatrist’s objectivity

and questioned the psychiatrist on the NCCHC standards relating to forensic information, which the psychiatrist was forced to admit he was not familiar with, thus undermining his own credibility and the opinion.

### Case 2

In another situation, a forensic psychiatrist working in the jail system was asked to conduct a competency evaluation for a defendant who was frequently in jail on minor charges, but had recently been released on his own recognizance on misdemeanor charges of criminal trespassing and possession of a controlled substance. The defendant presented to the court clinic. He was assessed as not competent to proceed with the adjudication process because of significant irritability, hostility, and paranoia involving his attorney and the court system in general. He had been noncompliant with treatment, which had included linkage with an assertive community treatment team. The psychiatrist recommended that the defendant be hospitalized to stabilize his symptoms and restore competency. Upon receipt of the evaluation, the court so ordered, and the defendant was admitted for further evaluation and treatment. He remained in the hospital for eight weeks. Several months later, he was re-arrested on assault charges, denied bail, and referred for psychiatric treatment in the jail. The same psychiatrist who conducted the forensic evaluation weeks before was assigned to the case. The defendant remembered that the psychiatrist had provided a report to the court that resulted in his involuntary hospital commitment for eight weeks, became extremely hostile, and threatened the psychiatrist, who was ultimately unable to establish any meaningful treatment relationship with the defendant. Anticipating that this would not be this defendant’s last incarceration, the psychiatrist subsequently insisted that any further contact with the inmate be limited to forensic evaluations with no treatment, necessitating transfer of care to a different provider for medication management.

### Discussion

Our first case presents a common dilemma where principles of beneficence and nonmaleficence (the first principles of ethics to apply in this situation where the psychiatrist was first a treater and the inmate was a patient) were at odds with the principles

of objectivity and justice, which the psychiatrist was considering at the time he assumed the role of forensic evaluator.

The treating psychiatrist should have limited the documentation to information that was clinically relevant. For those practicing in accredited facilities, the NCCHC Standard I-03 intends that health staff (i.e., those functioning as treatment providers) serve the health needs of their patients, meaning that they should not gather forensic information because of the professional and ethics-associated conflicts in taking actions that are typically done without inmate consent, that could lead to adversarial action against the patient, and that undermine professional credibility.<sup>12</sup> Forensic information can include blood or urine samples for the purposes of DNA testing or drug testing, but for psychiatrists, it can also include information obtained from the defendant relating to the current offense, or other criminal conduct not necessarily at issue before a court, but possibly discoverable if in the medical record.

It was appropriate to document in detail the inmate's history of substance abuse, because it was necessary to have this information to take appropriate steps that would prevent withdrawal symptoms. Documenting the last intake of alcohol or other drugs ingested helps a treating psychiatrist arrive at accurate diagnoses and treatment plans. Even ordering a test of blood alcohol level or obtaining a urine sample to test for drugs of abuse would not have been a violation of Standard I-03 if it was done to provide the necessary treatment. It was problematic, however, to document in detail the inmate's description of the crime. For instance, the psychiatrist could have documented, "patient was arrested for allegedly stabbing his girlfriend," rather than essentially documenting the inmate's confession. The psychiatrist elaborated on the inmate's crime far more than necessary for initial treatment purposes. It is possible that the inmate was not aware that his initial disclosures would be documented in detail and ultimately used against him. The inmate may have been withdrawing from drugs, alcohol, or both at the time he made the initial disclosures to the then-treating psychiatrist and thus exercised poor judgment by talking excessively about the offense. Later, the psychiatrist, in deciding to assume a role of evaluator, necessarily compromised his objectivity, as he had already formed preliminary opinions about the inmate. It was appropriate to consider the observations of the

forensic counselor and corrections officer in making either a treatment decision or forensic opinion, although these tasks should not have been performed simultaneously by one individual.

Psychiatrists who work in a correctional setting in both treatment and evaluator roles (for different inmates), by nature of their presence in the facility at times other than those dedicated to forensic evaluations, may have information about an inmate that could be favorable or unfavorable and can certainly challenge their objectivity as forensic evaluators. The psychiatrist may come across unsolicited information about the inmate that may contradict or support the initial opinions of the psychiatrist. For example, correctional officers or nursing staff may discuss information about the inmate in a setting where the psychiatrist cannot help but overhear it. There may be no avoiding hearing the facility's code for inmate assault on an officer or an inmate-on-inmate assault code and realizing that his client is involved. The psychiatrist may treat other inmates who may share information. For example, the psychiatrist may see a patient who is distressed at having to deal with the inmate's bizarre behavior on the same housing unit. Or another inmate may disclose that he was victimized or assaulted by the inmate being evaluated, who perhaps had denied any history of violent behavior. The psychiatrist may have opportunity, in the course of his or her normal duties, to observe the inmate in situations other than the forensic interview (for example, while the inmate is on work duty or on the housing unit). This information, should it come to the evaluator's attention, should not be ignored, but rather should be incorporated into the ultimate opinion to remain objective and render an unbiased opinion.

Ultimately, working in a correctional facility where the inmate is detained can provide helpful collateral information, but there is also the risk that knowledge gained by such an arrangement will not favor the inmate, and psychiatrists may face multiple challenges in remaining objective when conducting forensic evaluations.

In the second case, the psychiatrist's first role as evaluator allowed him to be neutral and objective and to perform an evaluation, keeping in mind the principle of justice in providing appropriate recommendations to the court (in this case, a period of confinement and treatment to assure that the defendant was able to have a fair adjudication, as it would

be unjust for an incompetent defendant to be subjected to further proceedings). However, the defendant perceived the results of the initial forensic evaluation as punitive, resulting in harm (the loss of liberty for a significant period). Therefore, from the inmate's perspective, the psychiatrist's initial actions (the forensic evaluation) interfered with forming any meaningful therapeutic alliance during a subsequent encounter, as the inmate may have had difficulty believing that the psychiatrist would subsequently act in the inmate's best interest in a treatment context. Under the circumstances, it would be highly unlikely that a therapeutic relationship would be established in what is already a somewhat coercive setting. Even evaluations that initially appear to have little to do with treatment (such as a straightforward evaluation for competency to stand trial), may have a negative consequence, such as a prolonged incarceration or hospitalization, resulting in the loss of freedom or delay in due process, owing to the forensic opinion. While hospitalized, the defendant may have missed or lost work and income, his housing may have been in jeopardy, and he may have missed out on important life events such as a child's birthday or major holiday. As shown in the case example, having a psychiatrist render such an opinion may create problems later when attempting to establish a treatment relationship or harm the treatment relationship if one was already in place before the forensic evaluation.

A related scenario that may prove to be complicated is accepting a private forensic referral while working within the correctional system. This arrangement has logistical advantages over being an outside evaluator. There are likely to be more opportunities to obtain timely and frequent access to relevant records. Since the psychiatrist is already frequently on site, access to the chart can be quick and efficient. Knowledge of the record-keeping system and the organization in general can also confer an advantage. Delays in obtaining up-to-date records may be significantly reduced. If the psychiatrist also enjoys a good relationship with the other mental health staff in the facility, he may also easily obtain collateral information and will have the benefit of easier access to these individuals for interviews and follow-up data and will quickly and easily obtain the most up-to-date information on the mental status of an inmate, which can be of importance in cases such as those involving competency to stand trial, in

which an opinion on an unstable inmate may change frequently. Corrections staff may also be more accommodating in terms of time and locations for interviews with the inmate, while an outside evaluator may be restricted to certain professional visit times for the evaluation. This advantage can become an important one, for example, if an inmate is participating in extended psychological testing where disruption of the test-taking process is inadvisable. When the question of fees arises, attorneys are usually quite happy to hear that travel time to and from the facility may be minimized or eliminated (i.e., not billed) if the evaluations are scheduled on days when the psychiatrist is already working at the facility.

There are also potentially negative aspects of such an arrangement. First, although there may not be an explicit contract or prohibition on behalf of the psychiatrist's employer, the situation may arise in which the psychiatrist, who otherwise would have been available to assume treatment or to provide a court-ordered forensic opinion regarding the inmate, is now unable to do so because he has now been privately retained. If there are few psychiatrists within the correctional system to provide services, having one psychiatrist kept from providing treatment or unavailable to answer a court order because of professional conflicts may create a strain within the system.

### Managing Ethics-Based Challenges

In smaller systems where psychiatrists assume responsibilities both as treaters and forensic evaluators, it may be almost unavoidable for them to assume both roles for the same inmate. Factors that should be taken into consideration when deciding whether to accept a dual role include the availability of an alternative evaluator who has not treated the inmate or conducted a forensic evaluation, how recent the prior contact with the inmate was, the length of any prior treatment relationship, and the nature of the relationship (i.e., a one-time evaluation to continue medication as opposed to six months of psychotherapy), whether the inmate has the capacity to understand the differing purposes of the forensic evaluation and an evaluation for treatment (the ability to understand a nonconfidentiality warning and how information may be disclosed and used), whether there is any objection on behalf of the inmate, and whether the evaluation is likely to be detrimental to the inmate.

The AAPL guidelines discuss the need to state explicitly the limits of confidentiality presented by the particular forensic situation. They address giving notice of reasonably anticipated limitations in confidentiality to inmates, third parties, and other appropriate individuals.<sup>10</sup> This is especially important when inmates are aware that a psychiatrist acts in a treatment role for other inmates in the same setting and to avoid creating the impression that what is intended to be a forensic evaluation for an inmate is for purposes of treatment.

Solutions for minimizing the conflicts in ethics of assuming dual treatment and forensic roles for the same inmate should include requesting additional time for completion of a nonurgent forensic evaluation to allow for a different psychiatrist to be assigned to each role. There may be instances where a psychiatrist conducting a forensic evaluation determines that the inmate is so symptomatic or in acute distress that the need for prompt treatment is obvious and most likely necessary for any meaningful participation in the forensic evaluation. If there is no immediate availability of a second psychiatrist who can assume a treatment role and a delay in treatment could prove detrimental to the inmate's mental health (for example, the likelihood of a psychiatric hospitalization, self-injurious behavior, or assaultive behavior without prompt intervention), evaluators should temporarily assume a treatment role and defer the forensic evaluation to a later time, ideally after a different psychiatrist has assumed care of the inmate for treatment. In these cases, the principle of beneficence trumps the principles of objectivity and justice, which are not as urgent.

Inmates who are re-arrested on new charges or are being returned to a correctional facility should be assigned to the same treatment provider they have had in the past for treatment during subsequent incarcerations. While this may not always be possible, it has the advantage of providing continuity of care, as well as allowing for other providers not in a treatment relationship to be available to conduct objective forensic evaluations. If all psychiatrists have been involved in treating the inmate, the psychiatrist with the least significant involvement in past treatment should be considered for a forensic evaluation.

Even if a psychiatrist is assigned to a forensic evaluation, clinical information that may be disclosed during the interview may necessitate clinical intervention to some degree, even though the psychia-

trist's primary role is not that of a treater. For instance, disclosure of suicidal ideation may require the psychiatrist to intervene clinically to place an inmate on constant-observation status.

The American Bar Association (ABA) provides the following guideline under the Criminal Justice Mental Health Standard, which may apply to some cases in which an evaluator becomes aware of relevant information, even if it was not the subject of the initial evaluation request:

Duty of Evaluator to disclose information concerning defendant's present mental condition that was not the subject of the evaluation: If in the course of any evaluation, the mental health or mental retardation professional concludes that defendant may be mentally incompetent to stand trial, presents an imminent risk of serious danger to another person, is imminently suicidal, or otherwise needs emergency intervention, the evaluator should notify defendant's attorney.<sup>11</sup>

The guideline goes on to state:

If the evaluation was initiated by the court or the prosecution, the evaluator should also notify the court.<sup>11</sup>

If the psychiatrist happens to be performing the forensic evaluation independent of employment with the correctional facility, additional considerations may become important. For instance, limited sharing of important information that could compromise the inmate's or the facility's safety and security may have to be disclosed to prevent harm, because there is also an implied duty to act in the best interests of one's employer, even though a particular evaluation is an outside referral.

In summary, there are numerous challenges that psychiatrists face when working simultaneously in corrections and private forensic practice involving criminal cases. Evaluators should adhere to the AAPL code of ethics, practicing honestly and striving for objectivity. As described in Section IV, "Psychiatrists practicing in a forensic role enhance the honesty and objectivity of their work by basing their forensic opinions, forensic reports, and forensic testimony on *all* available data."<sup>10</sup> Those practicing in NCCHC facilities should be aware of the guidelines that may affect their practice. Even if a facility is not accredited, the practice guidelines can still be helpful.

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