Ethics Challenges in Correctional Mental Health

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Forensic psychiatry has been developing ethics guidelines over the last 50 years. The forensic psychiatry guidelines have taken a somewhat different path from traditional medical ethics based on beneficence and nonmaleficence. In particular, for forensic psychiatrists, the ethics concept of the primacy of striving for an individual's benefit may conflict with duties to the justice system. I posit that correctional psychiatry is a branch of forensic psychiatry that has ethics characteristics of both systems and discuss a way of resolving some of these dilemmas. Even if it is practiced by suitably qualified forensic psychiatrists, correctional psychiatry demands its own variation of ethics principles. This variation involves the additional variable of acknowledgment of the duty to the security of the institution. I develop this theory and apply it to some day-to-day ethics dilemmas with which correctional psychiatrists deal. Developing a code of ethics for correctional psychiatry is important. I apply a theoretical code of ethics to the many daily dilemmas experienced by correctional psychiatrists.

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Beneficence and nonmaleficence form the basis of traditional medical ethics, which involves striving to benefit the person under assessment or treatment and, above all, do no harm. It has been recognized that practitioners of forensic mental health straddle two different ethics worlds. They act both as clinicians treating illness and agents of the justice system. This complicates their relationship with the core principles of medical ethics. Correctional mental health is a growing field that has features of general mental health delivery and features analogous to forensic psychiatry. As this field develops, there is some recognition that the delivery of correctional mental health demands its own ethics perspective. In this article, I discuss the development of the ethics related to the delivery of mental health and the ethics of forensic mental health and develop a conversation about some concerns distinct to correctional mental health. In doing so, we move closer to developing a code of ethics and guidelines developed from this code, which may help clinicians to resolve ethics dilemmas in correctional mental health.

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Correctional Psychiatric Ethics Framework

The late Professor Alan Stone challenged forensic practice by raising what he considered the lack of any stable ethics foundation to judge forensic mental health practitioners.[1] He opined that, as a medical practitioner, the forensic mental health worker is obliged to put the person under assessment or treatment first and therefore risks twisting justice, thereby necessarily distorting the truth. On the other hand, because forensic mental health workers are obliged to serve the needs of the justice system, they may harm the person. Stone saw this criticism as intrinsic, an inalterable facet of the forensic role. He argued that therapeutic strategies like building rapport and empathy are necessarily part of the forensic mental health practitioner's armamentarium to seduce the individual to disclose information that may be harmful when later revealed in a legal forum. Stone saw this dilemma as damning and inalterable. Shuman developed Stone's argument, explicitly related to the use of empathy in

forensic evaluations, which he found to be a form of deception and an infringement on the evaluee's autonomy.[2]

Paul Appelbaum proposed that forensic psychiatry establish its own principles.[3] He suggested that a duty to justice would be the ruling imperative, with the core values of truth-telling and respect for persons being of equal weight to beneficence and nonmaleficence. He warned, however, that the pursuit of truth and justice should be balanced by respect for persons, the same principle operating in other parts of social discourse. He commented that this approach protects the individual from any possible harm in the pursuit of justice but is not in direct conflict with the demands imposed by the pursuit of justice.

In a previous paper, I argued that correctional psychiatrists should be qualified forensic psychiatrists.[4] The primary reason for this is that forensic psychiatrists are well versed in and alert to ethics dilemmas. Also, forensic psychiatrists are well equipped to handle boundary violations, which are a common occurrence in correctional settings, and they have a working knowledge of the interaction between the correctional and forensic hospital and legal systems, which is essential. Forensic psychiatrists know the relationship between crime and mental disorders, including the role played by substance use disorders. They have experience with and knowledge about treating specific disorders, such as antisocial personality disorders, paraphilias, and anger problems, which are typically outside general psychiatrists' knowledge.

Traditional medical and psychiatric codes of ethics (e.g., those of the American Medical Association, Canadian Medical Association, American Psychiatric Association, Canadian Psychiatric Association, American Academy of Psychiatry and the Law, and Canadian Academy of Psychiatry and the Law[5–10]) cover broad areas but are not specific enough in resolving the ethics dilemmas that may confront correctional mental health workers daily. Some of these, although referred to as guidelines, provide guidance on a balancing approach but rarely on the specific problems encountered by correctional mental health workers. Consequently, the expectations of the dual roles and responsibilities may reduce to a set of common values, norms, and obligations applicable to correctional and forensic contexts.[11] Changing roles between ethics stances from one day to the next does not, however, resolve the dilemma.

Empathy and Detached Concern

In a paper discussing empathy in forensic psychiatry, my colleagues and I theorized that the concept of detached concern could be applied to forensic psychiatry.[12] Derived conceptually from the term forensic empathy suggested by Kenneth Appelbaum, we proposed the applicability of detached concern, first developed by Halpern,[13,14] to forensic psychiatry. We posited that this provides a means of using empathy in a forensic examination while maintaining objectivity and detachment and concluded that it is commensurate with the ethics guidelines, which state that striving for objectivity and honesty is the goal. I suggest this concept also applies to correctional psychiatry, given that correctional psychiatry has elements of both general and forensic psychiatry. The capacity to measure the amount of concern in the situation is an important element of correctional psychiatry.

Dual Role

Trestman noted that restricting the person's liberty presents society with many inherent ethics challenges.[15] He stated that incarceration intrinsically challenges the ethics of psychiatrists working in these settings. Ward framed the conflict as community protection versus the welfare of the individual offender.[16] He saw this as a clash of roles and their constituent values. Glaser extended this argument, conceptualizing that some treatment interventions, such as treatment of sex offenders in prisons, are more ethically coherent if understood as forms of punishment.[17,18] He argued, controversially, that cognitive restructuring as a form of treating sex offenders, which inherently causes distress and guilt, places societal benefits above those of the individual. He emphasized consideration of general norms of human rights and dignity as applicable in forensic and correctional situations. Ward justified this by arguing there is no intention to inflict suffering.[16] Levenson and D'Amora[19] stated that psychiatrists in the correctional context also undertake a variety of treatment modalities that are indisputably differentiated from punishment. I concur with this position. In my experience, most sex offenders who engage in treatment want treatment and give informed consent, which acknowledges that, as sometimes occurs in other treatments, there is some discomfort involved in the treatment process.

Similarly, in 2004, Day and others[20] noted that the treatment is justified because the client is helped in the

client's rehabilitation. Ward posited four ways that correctional psychiatrists can navigate these ethics complexities, including single-code primary mental health (clinical concerns are prioritized), single-code criminal justice (facility concerns are prioritized), balancing approaches, and hybrid approaches.[16] Beauchamp and Childress[21] invited physicians to consider autonomy, justice, beneficence, and nonmaleficence as the four guiding principles and then consider each situation in light of their obligations to individuals that they are assessing or treating and to other parties.

Allen suggested that psychiatrists must balance what he calls the six norms, where psychiatrists are required to consider the following factors: individual morality, human rights, law, public morality, organizational norms, and professional norms.[22] Similarly, a schema that balances the value of the individual's welfare against societal justice is one way of conceptualizing this problem.[23]

Candilis and Martinez[24] coined the term robust professionalism in addressing ethics dilemmas. They encourage psychiatrists to consider individuals they are assessing or treating and others associated with the case as parties to relationships, which might include security for instance, each with their own narratives that the psychiatrist must understand. Core principles include sensitivity to vulnerable evaluees, sensitivity to role problems, awareness of personal biases and internal states, honesty, and competence. They develop this as a multidirectional approach that allows correctional psychiatrists to be assigned unique duties that appear to separate ethics principles; however, Candilis[25] urged physicians not to ignore fundamental ethics roles simply because of the setting. This is an integrated approach in which individual loyalties and community standards work together to formulate a robust conceptualization of what it means to be a professional.

Candilis[25] stated that maintaining a clear boundary between treatment and forensic evaluation (defined as an evaluation ordered by the court and that is requested by a third party) is the crux of this matter. Trestman[15] also adopted this principle, adding that keeping clear boundaries between forensic evaluation and care delivery is crucial in prisons and jails. He considered forensic evaluation by a correctional psychiatrist to be an unacceptable breach of the patient-doctor relationship. Similarly, Strasburger and colleagues[26] advised against forensic mental health practitioners adopting the dual role of being both treater and court assessor, or wearing two hats. Although they were referring to a community context, one could argue the same principles apply if a correctional psychiatrist performs an assessment for the court. Strasburger noted that therapeutic intervention involves developing an empathic relationship and that the development of empathy has no role in and will not survive the adversarial conditions of court. The situation in which a correctional psychiatrist is asked (or ordered) to perform a forensic assessment for the court is only one of the dilemmas encountered in practice and a relatively easy one to recognize and eliminate.

Trestman[15] emphasized the centrality of human rights to a consideration of correctional psychiatry. Specifically, he noted that medical organizations affirmed physicians' obligation to refrain from countenancing, tolerating, or participating in inhumane or degrading treatment or torture. He stated that a individual's right to health is violated if a lack of prompt and appropriate identification and treatment of the illness causes significant worsening of the condition. Taking this concept further, he speculated that, if prisoners are kept in facilities without proper staffing, this could violate their right to health.[15]

Trestman[15] quoted the United Nations committee on economic and social cultural rights, stating that medical and mental health care in correctional settings should be equivalent to that which is available in the community. The American Psychiatric Association also adopted the position of the United Nations (UN) statement, proposing a higher standard, equivalency to the treatment that should be available in the community.[27] This standard could put an intolerable ethics standard on correctional psychiatrists.

Confidentiality

Most codes of ethics, and the guidelines that are derived from them, emphasize the role of confidentiality in the physician-patient relationship.[5,6,8,9] Treatment in correctional institutions can challenge efforts to maintain confidentiality. Trestman[15] described how correctional institutions are not designed to provide confidential access to care. He noted that, in many aspects of a correctional environment, such as administrative segregation, consultations with a psychiatrist are performed in the presence of correctional officers. This lack of confidentiality could be related to operational concerns, such as the time required or the potential danger

involved in bringing the individual to an office, or it could be related to security concerns, such as ensuring the individual is not violent to the psychiatrist.

Confidentiality is also a concern for those prescribed medication in a correctional context. In corrections, prescribers and the nurses administering medication must be cognizant of the significant prevalence of substance use disorders in this population and the consequent potential for medication misuse and diversion.[28] For this and other reasons, in these institutions, a correctional officer is commonly present in the medical line when administering medications. Sometimes there may be procedures to check that the individual is not using subterfuge to conceal the medication to misuse or divert the medication later. Therefore, correctional officers cannot help but see what medication the individual is taking. This could constitute a breach of confidentiality in some contexts.

One lens through which to review these dilemmas would be to consider the welfare of the mental health professional and correctional staff as part of the institution's security. Through this lens, the dual relationship entails a responsibility to both the incarcerated individual and the security of the institution. Another way to address this dilemma is to consider correctional officers as being part of the multidisciplinary team and, therefore, part of the circle of care.[14] In this model, the forensic psychiatrist should inform the individual under assessment or treatment of the limitations of confidentiality as part of the process of obtaining informed consent for the interview. This warning would include advising the interviewee that confidentiality would be broken if it were believed the institution's security was at risk of being compromised. Informed consent in the correctional setting would include advising the individual of these duties as well as informing the individual of other situations that might arise, such as a duty to warn, duty to protect a child, and the various other situations in which psychiatrists may need to breach confidentiality. Including these warnings ensures that the individual receives all the information needed to give informed consent.

Suicidal Persons

A problem arises in a correctional setting if a mental health professional assesses an individual and decides the individual is at risk of suicide. The risk of self-harm and suicide is significantly elevated in correctional settings.[29] Facilities have policies and procedures for screening and dealing with persons who need special observation because of the risk of self-harm or suicide, which could involve the mental health professional's breaching confidentiality to preserve the individual's life. Ideally, the person would be warned about the procedures that would be followed if the person became suicidal. A possible consequence of this, however, is that the person does not fully divulge suicidal ideas or plans to the clinician. It is hoped that the therapeutic relationship is strong enough that the person does not hide this information from the clinician, allowing preventive steps to be taken.

Another ethics problem is whether the restrictions instituted on incarcerated persons in what is commonly referred to as a suicide watch or high-risk suicide watch setting are reasonable and indicated. Cramer and colleagues[30] have suggested the principle of least restrictive alternative applies to suicide watch in a correctional setting.

Paul Appelbaum[31] describes the evolution of this term in mental health. In Appelbaum's view, this changed the courts' direction in forcing jurisdictions to create community facilities. The United Nations clearly enunciated consideration of least restrictive alternative in the principles for protecting people with mental illness and improving health care, requiring treatment in the community as opposed to hospital (Ref. 32, Principal #9).[32] This doctrine applies to the treatment of individuals treated in institutional or community settings, not to treatment within a particular setting.

In a correctional context, according to Cramer, this concept could apply to a situation in which a person is considered a suicide risk within the correctional institution. This argument could be extended to question whether it is legitimate to remove the person's clothes if the person intends to take an overdose of medication or whether it is fair to remove television and books if the person intends to attempt suicide by hanging. There is little research that guides us about the ability to predict the exact means that a person will use to effect suicide, conceivably incurring extra risk to the person and extra liability to staff and the institution. Given the contextual arguments about the possible misapplication of the concept of least restrictive alternative, I would submit that it should not simply be transposed from one context to the next

without careful consideration. Doing so could place an unrealistic burden on correctional psychiatrists.

Placement to Special Needs Units

Many correctional facilities have specific areas designated for people with mental disorders. These are variously called special needs units, special care units, mental health assessment units, and other names. It is generally accepted that mental health professionals will have a say in which incarcerated persons go to these units, depending on the criteria of the individual institution. Because correctional and operational staff are required to move them, a breach of confidentiality is necessarily involved. In some institutions, correctional staff are considered part of the circle of care, and the group decision may be to move someone to a designated mental health unit. If this is not the case, then at minimum, a breach of confidentiality occurs in notifying operations to move the individual. In these situations, specific diagnoses or facets of the illness may not be mentioned; if possible, the only information provided would be that the person is eligible for the mental health unit.

An adjunct in dealing with the confidentiality dilemma is to use measurement-based criteria. For instance, the Clinical Global Impressions (CGI)-C has been validated for use in correctional populations.[33] This instrument is a simple way of enumerating the functionality of an individual at a given time that does not require disclosing a diagnosis, thereby limiting the information that it is necessary to share. I work at an institution that has successfully instituted this measure as a guide to moving people among three levels of special needs units with varying criteria, depending on level of functioning.

Disciplinary Responsibility

Adjudication and consequences for disciplinary infractions or misconduct have long been part of the policies and procedures of North American jails and prisons. Consequences have included a loss of privileges, which could mean a period in disciplinary segregation. Knoll[34] drew attention to a theory that people with a mental disorder are more likely to break rules and this could be because of symptoms of their given diagnosis or mental disorder. Metzner[35] discussed the possible role of mental health professionals in the disciplinary process. He stated this has largely been driven by class action suits, such as *Wolff v. McDonell*.[36] Traditionally, rule violations by an incarcerated person lead to some kind of hearing. In *Wolff v. McDonell*,[36] the U.S. Supreme Court ruled that this demands due process, involving a hearing where witnesses can be called and parties may present evidence. There is some allowance given to the nature of correctional institutions, such that these hearings are in some ways analogous to parole hearings. The court adopted a compromise position in that there should be effective but informal hearings with minimal due process. Obegi[37] discussed this process in the California correctional system. He compared the determination of disciplinary responsibility with insanity evaluations, stating that California correctional systems have adopted something akin to the Durham rule as the standard for responsibility.

From an ethics perspective, this situation could raise the concern of dual agency, because of a shortage of mental health staff. Additionally, it would normally take a forensic psychiatrist several hours to complete a full assessment of criminal responsibility and formulate a conclusion, whereas in the correctional setting, an opinion must be formed in such a short time that it raises the concern of whether any opinion can be legitimate. As pointed out by Metzner,[28] this process could increase tension between correctional staff and mental health staff. Further, it has the potential to drain already limited mental health resources to a procedure that may have limited value. On the other hand, Tamburello and Haston[38] argued that mental health involvement can be therapeutic. In some systems, certain incarcerated persons are designated as experiencing a loosely based category of serious mental illnesses and are thus exempt from certain consequences of their behavior.

Duty to Warn

In most jurisdictions, there are situations in which breach of confidentiality is necessary,[39,40] including a duty to inform authorities if a child is in danger or if a person threatens bodily harm to a third party. In some jurisdictions, reporting is mandatory, whereas in others, it is discretionary. Given the nature of the circumstances, it is not uncommon that persons incarcerated in correctional institutions may threaten third parties or suggest they are dangerous to a third party or child. In such circumstances, it is important to assess the individual fully and determine the

viability of the threat.[41] For example, if a person is serving a life sentence in a maximum-security prison and is unlikely to be released for 20 to 30 years, then threats made to someone in the community may not be realistic. Careful assessment might reveal that the individual still has criminal connections in the community who could carry out this threat. A similar analysis might apply when an incarcerated person threatens to harm a staff member in the institution.

The duty to warn may overlap with the dual relationship; that is, the psychiatrist has a responsibility to both the person diagnosed with a mental illness and to the security of the institution. In such situations, an assessment of risk includes determining whether the individual is likely to follow through on the individual's threat, considering all circumstances, including the viability of the threat, future access to the person at risk, and an assessment of steps that could or should be taken to prevent access to that person. Appropriate actions include informing the institution, the police, and, if the person is a minor, child protection agencies. Consideration should also be given to instituting or altering treatment, or committing a person diagnosed with mental illness under the relevant mental health laws. Depending on the circumstances, treatment may be voluntary or involuntary and will address underlying mental disorders that might be relevant to the threat (for example, psychosis).

Reports of Victimization

Violence among incarcerated persons is a common occurrence in correctional facilities. A particular problem arises when one incarcerated person informs the mental health professional that the person has been assaulted by another, which hitherto has not come to the attention of the staff. The professional's first obligation is to ensure the safety and security of the incarcerated person. According to an unspoken code, incarcerated persons should never tell a staff member of rule-breaking by another. If the mental health professional takes steps that do not protect the individual, the professional may be putting the individual at risk of harm. It is reasonable for the mental health professional to discuss possible options with the individual and come to an agreed upon course of action that will protect the individual in the short and long term. This might involve moving the person, disciplinary or criminal charges against the perpetrator, or moving the perpetrator. Respect for confidentiality also needs to be balanced against protecting the security of the institution, such as protecting other vulnerable people from the same assailant. In practice, this often involves delicate negotiations in consultation with security staff. In some jurisdictions, mental health professionals are involved in assessments of responsibility in these circumstances,[42] and Tamburello[38] argued that this can be therapeutic.

Informed Consent to Treatment

In most jurisdictions, a person encountering the mental health system has the right to make an informed choice about whether to consent to or refuse treatment. Generally, individuals are presumed to be capable of giving informed consent. Informed consent includes a process whereby the clinician administering the medication explains the nature and purpose of the treatment and the reasonably foreseeable risks and benefits. This procedure may contain information about alternatives and the risks of refusing treatment. The same principles apply to persons diagnosed with mental illnesses in correctional settings as in any other setting, in that medication should only be administered with the individual's informed consent.[15,43] Ontario has a legal mechanism to declare a person incapable of providing informed consent where applicable, and other jurisdictions have analogous processes. In such cases, medication can be administered against the individual's will in accredited psychiatric facilities, which may be located within or outside of correctional facilities. Depending on the policies of that jurisdiction, correctional institutions may have a procedure for treating individuals diagnosed with mental illnesses against their will.

Typically, the individual has certain protections and a right of appeal, which might involve applying to a review board, similar to a hospital setting. If the individual has the capacity to give informed consent, there is almost no disagreement in the literature that the proper procedures should be followed. If the individual refuses treatment and is capable, treatment cannot be given against the individual's will except in cases of emergency and certain other situations depending on the jurisdiction. In some jurisdictions, the mental health section of the correctional institution may be an accredited psychiatric hospital. In this case, the procedure to be followed is equivalent to those in the psychiatric hospitals in that jurisdiction. Therefore, it is incumbent upon clinicians to be aware of the policies, procedures, and legislation relevant to the particular institution.

Research in Corrections

A recent case in Ontario[44] highlighted some of the problems with research in a correctional setting.[45] In this case, a maximum-security forensic hospital (formerly known as Penetanguishene) was involved in a civil tort suit based on breach of fiduciary duty by two psychiatrists and the government ministry that employed them. The case involved the use of extreme experimental actions involving individuals' being locked, naked, in encounter capsules for days and being given a variety of hallucinogenic drugs, including lysergic acid diethylamide (LSD) and others. This occurred as late as the 1960s and 1970s for treatment of individuals who had been found not guilty by reason of insanity. The basis of the claim was that the patients, who were held against their will and therefore in a coercive environment, experienced serious mental illness and were not able to give informed consent. The two doctors involved were found to have perpetrated assault and battery and breach of fiduciary duty. Another notorious example is the Stateville Penitentiary malaria study that occurred in the 1940s,[46] resulting in the United States' severely limiting research on prisoners in 1976.[47]

A number of ethics codes pertain to the principles of research, which I would suggest apply especially to research in correctional institutions.[48–56] Trestman[15] noted that these guidelines were developed to protect vulnerable groups, but it has been argued that they may overprotect groups to their own detriment.[57] Using a different case at the same hospital as the case noted above, Bradford and colleagues[58] stressed the importance of using informed consent, the principle of non-maleficence, and a just and requisite distribution of research risks and benefits in relation to research on incarcerated individuals in a maximum-security environment. It has been said that a conservative approach to using the various principles is applicable in correctional institutions.[59] It could be argued that informed consent is not possible in coercive environments. On the other hand, Elger[60] rejected the conservative approach in arguing that the right to care includes a right to improvement in care. Careful risk-benefit analysis is a minimum guide to research in prisons, and perhaps an even more specific set of principles may be required.[61]

It may be convenient to think of research on prisoners in three categories. First, there is convenience research. This describes a situation where it may be convenient to do research on an accessible and captive population, even if it may not benefit the population in prison directly. Second, there is prison research. This refers to research on the effects of prison interventions that may or may not benefit the population. The third, treatment research, focuses on the types of treatment intervention that may benefit incarcerated individuals. Application of the principles enunciated above may vary according to the type of research anticipated. Some research is intended to improve the system and is not necessarily helpful to prisoners or could, in fact, be harmful in resulting in longer incarceration by limiting early parole to those who refuse to participate.[62] Clearly, researchers must consider the impact of hidden coercion in the process of obtaining informed consent when conducting research in prisons. One study demonstrated that 15 percent of participants believed they would obtain some benefit by participation.[62]

In conclusion, research in prisons and jails is possible and ethical if researchers are willing to pay attention to the nuances of informed consent, especially in relation to implicit coercion. It is recommended that a university or clearly independent research ethics board review the principles before initiating the research.[40] Trestman[15] goes as far as to argue that, as a body, correctional mental health has an ethical obligation to actively further the research agenda in correctional psychiatry. I would suggest that this includes specific attention to the limits of informed consent, risks and benefits to the individual, the individual's appreciation of these risks and benefits, and careful independent review of proposed research.

Conclusions

Ethics continues to be a topic of considerable debate in correctional psychiatry and one that is deeply unsettling to clinicians involved. Ward[16] identified this as a conflict or form of value pluralism between professional norms (those concerned with community protection versus those related to client well being) and between codes of ethics of the profession and the institution or employer. Candilis and Martinez[24] contend that a substantial ethics analysis approach to resolving ethics problems involves the practitioner's personal, professional, and social values. They endorse drawing from multiple ethics perspectives or values when undertaking forensic and correctional work, leading to a more nuanced ethical practice and greater integrity. Building on the work of Richardson[62] and

Childress,[63] Hanson[64] described a step-by-step approach to resolving ethics dilemmas. The first step is identifying the problem, including the views of the various parties. Once these views are identified, they are applied to the case using ethics techniques, such as specification (i.e., translating abstract principles into concrete rules and applying to specific situations) and balancing, to construct an action plan. It is important to ensure that each participant can justify the plan within the participant's own set of norms.

The goal of this article is not to arrive at specific solutions to defining what is ethical and what is unethical. Rather, the goal is to raise practitioners' awareness of and ability to recognize ethics dilemmas and approach each in a thoughtful manner. In his article on dialectic principlism, Weinstock[65] endorsed traditional approaches to identifying, weighing, and balancing conflicting principles[21] by recognizing an ethics problem when it arises, weighing competing interests, and identifying conflicting obligations. At this stage, practitioners can prioritize and balance the various conflicting principles in the context of personal and societal values. The purpose of the approach is not to come to a definitive conclusion about what is right and wrong but to determine the most ethical action. It should be noted that, although influencing policy may further these aims, correctional mental health workers have limited input into the policies and procedures of the institution that reside within the purview of administration and legislative policy. Nevertheless, highlighting ethics conflicts that arise in institutional practice can serve to initiate change.

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