Ethical issues in forensic psychiatry in penal and other correctional facilities
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Purpose of review
Forensic mental health practitioners, especially psychiatrists working in jails, prisons or other correctional facilities, face special problems that are unlike others encountered in bioethics.

Recent findings
Literature published during the past year shows that the forensic psychiatrist has to adhere to role clarity: as a physician, he is primarily obligated to the treatment and well being of the incarcerated patients and is not exclusively an agent of social control. Moreover, the general conditions in a therapeutic setting (e.g. dealing with medical confidentiality) have to be clear and transparent to the patients. Different ethical models building a fitting framework for forensic practice are used.

Summary
Forensic psychiatric practice in penal and other correctional facilities poses particular ethical dilemmas. There is a great need for international humanitarian law, which serves both to protect vulnerable prisoners and to shield health professionals who treat prisoners with respect and dignity from abuse or penalty. It must be a common objective to find the right balance between protection from exploitation and access to research beneficial to prisoners.

Keywords
ethics, forensic psychiatry, prison psychiatry

Introduction
A double knowledge in psychiatry and law defines the subspecialty of forensic psychiatry and provides the ethical foundations for its practitioners [1]. The core concern underlying all the ethics-related precepts is the relationship between the psychiatrist and the evaluatee [2]. In psychiatric ethics, the dual-role dilemma refers to the tension between psychiatrists’ obligations of beneficence towards their patients and conflicting obligations to the community, third parties, other health-care workers, or the pursuit of knowledge in the field. These conflicting obligations present a conflict of interest in that the expectations of the psychiatrist, other than those related to patients’ best interests, are so compelling. This tension illustrates how the discourse in psychiatric ethics is embedded in the social and cultural context of the situations encountered. It appears that as society changes in its approach to the value of liberal autonomy and the ‘collective good’, psychiatrists may also need to change [3].

It has been argued that prison is harmful, that it deprives individuals of basic human rights and needs, bringing physical, mental and social harm to prisoners and rendering them powerless and institutionalized (e.g. [4]). Prison social environments have an important bearing on prisoner health, in terms of prison organization, culture and relationships inside and outside prison, loss of privacy, overcrowding, social isolation, restrictive and repetitive routine, low stimulation and the prisoner social hierarchy. Although today’s prisons are not completely closed systems or ‘total institutions’ [5], the restrictions and deprivations imprisonment legitimately imposes require a theory of legal punishment’s justifying aims [6]. Reasons for punishment involve four key theories: retribution, deterrence, rehabilitation and incapacitation. The increasing use of incapacitation to prevent individuals from committing future criminal acts is reflected in the growing prison population [7].

The role of a forensic psychiatrist
The professional medical role of a psychiatrist and/or psychotherapist working in prison has inherent conflicts within. On the one hand the doctor acts according to the requests and interests of his/her imprisoned patient and, following the Hippocratic oath, assigns the highest priority to the preservation and restoration of the patient’s health, yet, on the other hand, he/she is an employee of that authority which, in carrying out the punishment required by the state, implements measures which may well damage the prisoner’s health. Unlike a surgeon or...
physician working in prison, who treats illnesses which may be preexisting or which may have occurred regardless of imprisonment, psychiatrists in prisons deal with large numbers of individuals with ‘prison reactions’, which have arisen directly as a consequence of imprisonment. To a certain extent the function of the psychiatric and psychotherapeutic treatment provided is to keep the prisoner fit for imprisonment, serving a pacifying and mollifying function. Prison psychiatrists find themselves in ethically questionable territory if they carry out psychopharmacological or other medical interventions for which there is no primary medical indication, in order to allow judicial proceedings and the penal system to run smoothly [8].

In cases of psychiatric reports on refugees facing deportation, which bear considerable diagnostic and prognostic difficulties, the psychiatrist has a major impact on an individual’s life which can have grave consequences including deterioration of existing mental disorders [8]. The most severe role conflict for psychiatrists exists in countries with capital punishment where forensic experts are used to assess the ‘competency to be executed’, which could be achieved by treating the mental illness. Keane [9] argues in this context that physicians may be causing harm to co-victims such as murder victims’ relatives when they delay, halt or advocate against an execution.

Of particular concern are disciplinary measures which are coercive by nature. Mentally disordered prisoners are more likely to become the subject of disciplinary measures owing to misbehaviour that may be caused by the disorder. It is well known that specific coercive measures (e.g., solitary confinement) are likely to aggravate mental disorders. Thus, it is crucial to assess the psychological status of a prisoner prior to implementing such measures in order to avoid any additional harm. There are European countries where all prisoners requiring punitive or disciplinary measures – or at least any prisoner known to suffer from a mental disorder – will be assessed for fitness to undergo disciplinary measures prior to their implementation. In other European countries, such an assessment is not stipulated [10]. This participation of medical personnel in the administration of punishment raises considerable ethical problems: discipline and punishment are security and not health issues, and therefore the physician, who should be available to attend to the medical needs of a prisoner under any form of punishment, has no role in deciding upon the administration of such punishment, for example in certifying that a person is mentally fit to withstand such a punishment, and should not be available for the purpose of supporting the prisoner’s capacity to sustain a punishment [11].

Prison psychiatrists should not, as a matter of principle, and in order to avoid a conflict of roles, assess their own patients [12]. The same refers to psychologists [13]. Despite the complex ethical demands of this unique practice area, it has received little attention within mainstream bioethics [14]. Some authors [15] argue that an overarching model of human rights can supplement the ethical code and thus offer an additional framework for the clinical work.

Austin et al. [14] argued that relational ethics with core elements identified as engaged interaction, mutual respect, embodied knowledge, uncertainty and vulnerability, and interdependent environment, is a fitting framework for forensic practice and, further, that forensic settings are the very place to test the validity of such an ethic.

Candilis [16] stresses the usefulness of robust professionalism for settings in which most forensic psychiatrists practice. This model recognizes the formative influence of personal values (a set of well regarded personal principles that remain somewhat stable over time and are coherent), the salience of personal identity in one’s work (verbal expression of those values and principles), and the connection of personal and professional identities (consistency between what one says and what one does). Robust professionalism is put into practice through the behaviours that operationalize the theory which have been called the habits and skills of the ethical practitioner such as automatic confidentiality warnings, openness or transparency.

Prison psychiatry

The vast majority of prisoners have a plethora of needs which combine at different levels of severity. Frequently there are double or triple diagnoses. This complexity of needs often amalgamates to include mental and physical illnesses, homelessness, unemployment, and drug and alcohol addiction [17]. Prisoners with a personality disorder may be considered responsible for their own condition, which is also often viewed as untreatable [18]. Those with a co-occurring psychiatric and substance use disorder exhibit a substantially higher risk of multiple incarcerations than inmates with a psychiatric disorder alone or substance use disorders alone [19].

The physician (even psychiatrist) working in prison is obliged to overcome the moral revulsion at the crime attributed to the prisoner and proceed with an ethical approach to treatment despite feelings to the contrary. A prerequisite is to control the counter-transference processes. Prisoners presenting psychotic symptoms may be prone to being denied needed mental health services if evidence of psychopathic traits is used to bolster presumptions of malingering, although findings fail to support the clinical intuition that individuals with higher
levels of psychopathy are likely to be more adept at malingering [20*].

For mentally disordered prisoners, there is often an increased risk of being victimized [21], as well as the potential for high rates of decompensation and deterioration. Some authors have suggested that the suicide rate among prisoners is a marker of the inadequate or even inhumane treatment in prisons [22].

**Principle of equivalence**

If one accepts that mentally disordered prisoners should be treated in penal institutions, possibly in a hospital wing/ward within the prison, then the principle of ‘equivalence’ of care in the community and therapeutic provision for incarcerated mentally disordered persons should prevail (e.g. [23]). This essential principle should also be applied to medical treatment of addicted prisoners and of withdrawal symptoms in prison. However, medication-assisted treatment, endorsed by international health and drug agencies as an integral part of HIV prevention and care strategies for opioid-dependent drug users, are unavailable for most prisoners even if they are available to the general public in a particular country [24].

It is doubtful whether the majority of prisoners with mental disorders receive appropriate care such as that mandated by the European Convention on Human Rights and other international charters [11,25]. A number of boards in the UK stated that, too often, people with severe mental illnesses are held in segregation units, where they endure an impoverished regime [26]. The Trenčín statement of the WHO [11] suggests that mental health and resilience can be protected and even promoted despite the inevitable constraints from the imperative of security [27]. Nowak and Zarraluqui [28] argue that the Convention on the Rights of Persons with Disabilities represents a paradigm shift that requires States to modify and adopt laws, policies and practices that fully respect the right to liberty of persons with disabilities, and their equal enjoyment of rights while in detention, including the right to be free from torture and ill-treatment.

Existing regimes of medication and the autonomy to self-medicate established in the community are disrupted and curtailed by the dominant practices and prison routines for the taking of prescribed medication. The continuity of mental healthcare is undermined by the removal or alteration of existing medication practice and changes on entry to prison which exacerbate prisoners’ anxiety and sense of helplessness. Prisoners with a dual diagnosis are likely to be doubly vulnerable because of inconsistencies in substance withdrawal management [29].

**Consent to treatment**

Consent to treatment should be sought from all patients, including offenders with a mental disorder, provided they have capacity to consent. Furthermore, obtaining the patient’s consent, especially in the case of psychiatric pathology, is essential if a ‘therapeutic alliance’ is to be formed which is likely to make the patient more committed to the treatment offered.

A controversial issue in forensic psychiatry and a classical ethical dilemma is whether an incompetent person has the right to refuse treatment or, framed differently, whether the right to refuse treatment supersedes his right to sanity. Some might argue that it is the duty of the treating psychiatrist to zealously persuade the patient, his guardian and, if need be, the courts, that a proposed treatment is indeed in the best interest of the individual, regardless of an expressed (and sometimes psychotic) wish against it. The question is whether the courts recognize a patient’s right to receive treatment so as not to remain psychotic (implicitly acknowledging the subjective torment and, at times, sheer terror of the psychotic individual). Abramowitz [30] suggested that the courts will usually support treatment for an individual lacking capacity as long as it is consistent with professional standards of care, however, without asserting a specific, inalienable right of the individual to receive treatment. On the other side the practice of force feeding of mentally competent individuals on hunger strike is inconsistent with medical ethics [31]. The need for medical care of prisoners who persistently refuse food in order to make a protest is rare but challenging. Knowledge about the hunger strike quickly spreads and gets into the political arena. Governments want to resist the demands, which often have political overtones, but also do not want prisoners to die because of fear of a backlash of public opinion. Pressure is therefore brought on the prison healthcare staff, including psychiatrists, to keep the prisoners alive, if necessary, by force feeding. However, a doctor must obtain consent from the patient before applying his skills to assist him [8].

Other conflicting areas are the failure to offer electroconvulsive therapy (ECT) as a standard of care issue, the perception of state-mandated ECT as punishment, and the capacity to provide informed consent for ECT while on a forensic unit [32].

**Confidentiality**

The basic principles of confidentiality apply to all doctors, including forensic psychiatrists, and most European countries have laws and/or professional guidance to govern this complex area (e.g. [33]). Although this has traditionally received less attention, principles of
confidentiality also apply to other professions, for example psychologists [34]. The doctor must not disclose information about the patient to third parties without the patient’s consent except in a limited number of clearly specified circumstances, usually to prevent serious harm to the patient or others, such as when cases of ill-treatment are noted. If such a situation arises the patient should be informed about the disclosure and the reasons for disclosure clearly documented.

For example, psychiatrists may be expected to report to authorities serious inmate rule violations and plans for escapes or disturbances [35]. There would probably be different opinions among mental health professionals about where to draw the line for breaching confidentiality; for example, what is the exact definition of a security-threatening emergency [36]? Pinta [36] suggests a special decision-making process with the elements establishment of ethics-based priorities, period of deliberation, making a decision and taking responsibility for the decision as the essence of any ethics-based decision.

Research
While epidemiological research is generally welcome in prison settings in order to increase the evidence on mental disorders and mental healthcare in the prison context, clinical research is a different matter [8]. The participation of psychiatric patients, particularly those who are incarcerated, in clinical research poses significant ethical challenges. Research has moved from the exploitation of a vulnerable population to become overly protective and restrictive. However, administering treatment without a sound evidence base, based on thorough research, does not appear to be a desirable alternative. Therefore, guidance with regards to the ethics of human experimentation is crucial. Correctional research is now maturing into a discipline that emphasizes the importance of research findings that benefit prisoners rather than coercing a susceptible group simply for convenience and economy [37].

Some European countries generally prohibit biological and pharmacological research on prisoners, others allow such research in principle but emphasize the importance of obtaining informed consent of the prisoners, permission of the responsible authorities, and ethics committee approval [10]. In the USA, state policies on compensation of incarcerated research participants vary widely in terms of allowing compensation as well as clarity of and ease of access to policy information [38]. While the intention to protect vulnerable prisoners from being coerced into participating in research is in principle commendable, it also raises a number of questions. For example, how is progress regarding treatment to be made if relevant research is not permitted and what are there-fore the ethical implications of NOT conducting research in prisons? Furthermore, a ban on all biomedical research in prisons appears to stem from a perception of prisoners as incapable of making informed choices for themselves. It discriminates against prisoners in depriving them of the opportunity to voluntarily engage in research projects, which they may well find an interesting and rewarding experience [8]. Adequate healthcare facilities for all prisoners in the involved prison should be in place and fair and random recruitment procedures should be guaranteed. For research in prisons to be ethical, it must be interested in ensuring a stronger and more effective safety net for prisoners when they return home and must ask what safeguards are in place for those who have engaged in clinical trials while in prison should they later become ill or infected [39]. Research ethics committees should identify their independence from sponsors, investigators and prison administration by statements of absence of conflicts of interest for each member, should be composed of a fair distribution of scientists and lay members of different gender, race, cultural and social background and should be obliged to include prisoners or prisoner representatives as members of their boards. It must be a common objective to find the right balance between protection from exploitation and access to research beneficial to prisoners [40].

Conclusion
Regardless of the ethical principles and scholarship that may be applied in individual countries or health systems, there is a great need for international humanitarian law, which serves both to protect vulnerable prisoners and to shield health professionals who treat prisoners with respect and dignity from abuse or penalty. Such laws should be reaffirmed, and the rare occasions on which the rights of individuals can be overridden should require justification by appeal to principles [41]. Finding the right balance between protection from exploitation and access to research beneficial to prisoners must be considered as a common objective.

References and recommended reading
Papers of particular interest, published within the annual period of review, have been highlighted as:
• of special interest
** of outstanding interest
Additional references related to this topic can also be found in the Current World Literature section in this issue (p. 487).


The author describes different approaches to forensic ethics and tries to conceptualize robust professionalism for forensic psychiatry.


This article summarizes the key recommendations from the National Institute for Health and Clinical Excellence (NICE) on the management of both borderline and antisocial personality disorder.


This review deals with clinical and conceptual errors that contribute to false attributions of malingering in forensic evaluations and includes ethics-related problems associated with rates of misclassification.


Konrad N. Forensic psychiatry in dubious ascent. World Psychiatry 2006; 5:93.