Forensic Files

SETTING UP A DEATH ROW PSYCHIATRY PROGRAM

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ABSTRACT

Death row psychiatry contains a complex set of clinical, ethical, and legal questions. This Forensic Files column makes a case for correctional institutions starting death row programs to address these issues through uniform policies. A list of the relevant issues is provided. Specific issues discussed include death row psychiatric assessment, considering "justifiable" depression, treating for competency to be executed, and balancing boundaries between clinical and forensic work.

KEY WORDS

Forensic psychiatry, correctional psychiatry, death penalty, competency, mood disorders

INTRODUCTION

Death row psychiatry may represent the epitome of ethical and legal challenges within psychiatry. Some people may believe that providing diligent medical treatment to inmates waiting to be executed is unnecessary, or even a waste. While everyone has a right to their opinion, the law provides that death row inmates have the right to physical and mental health treatment up until the very moment that they are executed.

The right to treatment has been most famously supported in the 1976 United States Supreme Court case Estelle v. Gamble, in which it was ruled that deliberate refusal of a prison system to provide necessary medical care to an inmate amounts to cruel and unusual punishment, violating the 8th Amendment of the Constitution.[1] In the last edition of Forensic Files, we learned that inmates have the ability to sue prisons with "1983 claims" for violations of rights guaranteed to them by the Constitution.[2]

In today's complex world, mental health and the legal system have evolved to form many areas of overlap that are often daunting to sort through. However, ignoring issues because they are too complicated is simply not an option. In a prison with a large death row population, it may be prudent to form a multidisciplinary team of professionals specifically designated to setting the death row mental health treatment policies. This team would be tasked with considering the clinical, ethical, and legal complications involved and creating policies to address them.

The premise behind this is that if things were to go wrong, it would be better to be challenged on the details of a thoughtful clinical or forensic policy than to be challenged on a series of inconsistent and arbitrary actions. For example, it is not uncommon for a death row clinical psychiatrist

to be contacted by a forensic psychiatrist or an attorney with requests for information, opinions, and records. While some psychiatrists may have different views on how to best handle this, some will not have any idea at all.

In general, a death row psychiatry program should have these two main goals: 1) acknowledgment of the unique issues and challenges when treating death row inmates and 2) alteration of actions when appropriate.

DEATH ROW PSYCHIATRY ISSUES

The issues likely to arise when psychiatrically treating death row inmates can be broadly categorized into clinical and ethical/forensic.

While several issues are addressed here, this column cannot give definitive answers to all of them because legal and ethical interpretations can be subjective and relevant legal standards will vary by state. However, acknowledging that such issues should be addressed is a good first step. Table 1 lists examples of questions to be addressed in a death row psychiatry program.

Death row psychiatric assessment. When working with death row inmates, a careful history and timeline is needed to discern whether psychiatric symptoms are reflective of premorbid illness or are the product of current stressors of the incarceration. However, gathering history from death row inmates may be difficult due to poor communication skills, malingering, limited sources of collateral information, lack of records, and uncooperation. In some cases inmates may even be instructed by their attorneys not to speak with psychiatrists.

For a physician working in a correctional setting, it can be frustrating to realize that policies of the prison system itself often contribute to worsening mental illness of the inmates. However, when assessing mental illness in a death row population, it is important to consider the effects of the following potential risk factors:

1. Almost half of incarcerated inmates who commit capital crimes suffer from mental illness prior to their crime.[3] Antisocial personality disorder has been correlated with posttraumatic stress disorder (PTSD), mood disorders, anxiety disorders, and substance abuse.[4]
2. 'Supermax' confinement usually involves isolation and sensory deprivation. "Death row syndrome" has been described, and inmates living under such conditions have been seen to suffer higher than normal rates of anxiety, dissociation, and psychosis.[5,6]
3. Psychological awareness of impending execution can also be traumatizing. In fact, United States courts have ruled that long periods on death row themselves could amount to cruel and unusual punishment.[7,8]

Considering "justifiable" depression. Most definitions of mental disorders include social factors as a relevant potential cause. Bereavement is listed as a condition separate from major depression in the *Diagnostic and Statistial Manual of Mental Disorders, Fourth Edition*, but it can be associated with severe symptoms.[9] Bereavement is defined by loss, and it is hard to imagine any loss greater than the realization that your time on Earth is about to end.

If a "pre-execution syndrome" was defined it would include many symptoms asociated with clinical depression, such as hopelessness, morbid thoughts, and guilt. These symptoms are formulated as pessimistic delusions when part of a depressive syndrome, but death row inmates would arguably be delusional for *not* exhibiting these "symptoms.""

When depressive symptoms appear appropriate to circumstances, does that mean they are normal? Does it mean they do not reflect illness? The concept of "justified depression" is complicated both scientifically and linguistically, and has been discussed by practitioners when treating depression in the elderly.[10]

In the end, it does not really matter what you call it. Whether or not mental health symptoms are deemed appropriate, it is my opinion that if the symptoms cause dysfunction, distress, and loss in quality of life, they should be treated. More research needs to be done on "justifiable depression""to better understand its prognosis and treatment.

Treating for competency to be executed. The ethical challenges associated with psychiatric treatment of death row inmates can be seen as early as the initial trial. Is it ethical for a psychiatrist to provide testimony during a murder trial that could be detrimental to the defendant's case? Generally, the literature supports this role, as long as the "ultimate issues" are not addressed.[11]

Returning to the correctional arena, there is a long history of precedents behind the inmate's right to be competent for execution. Landark cases Ford v. Wainwright and Atkins v. Virginia established that "insane" inmates and those with mental retardation could not be executed.[12,13] Panetti v. Quarterman clarified that a rational understanding of the nature and purpose of an inmate's sentence was

required in order for him or her to be deemed competent.[14]

Mental health associations have challenged the ethics of the death penalty, in general, and also the roles of physicians in executions.[15,16] One issue of debate has been the fact that restoring an incompetent inmate to competency contributes to the patient's ability to be legally executed. Is this a violation of the Hippocratic Oath?

While it may seem that the goals of the doctor and the state are at odds, it is not sensible to ever call treatment of disorders unethical. Inmates have established the right not to be forcibly medicated for the purpose of restoration.[17] However, a psychiatrist withholding treatment for his or her own political reasons may be both criminal and counterproductive. A finding of incompetence to be executed may cause an immediate extension of life, but it is also likely to increase psychological suffering over the long term.

Focusing on only treating symptoms while avoiding specifically providing restoration treatment is a possibility. However, because restoration is still a likely outcome regardless, this strategy will be of little consolation to those who feel that restoring incompetent death row inmates is a violation of their personal ethics. For correctional psychiatrists who cannot separate their politics from their work, they may be better suited to a different work setting.

Balancing boundaries. While treatment and forensic issues often seem intermingled, it is important make an effort to separate them as much as possible. Forensic psychiatrists have talked about the importance of not "wearing two hats," suggesting that treating doctors should not perform forensic evaluations on their own patients.[18]

TABLE 1. Sample questions to be addressed by a death row psychiatry program

CLINICAL

1. What psychiatric symptoms and disorders are most commonly seen in death row inmates? What risk factors should be considered?
2. How is diagnosis affected by the fact that being on death row may lead to justifiable hopelessness, guilt and negative outlook?
3. During the weeks prior to an execution, should the threshold to use medications be lower? Higher? Should tolerance, addiction, and long-term side effects of medications be less concerning?
4. Should therapy continue up until the date of execution? What would be the goal?
5. Will discussing a patient's execution worsen anxiety or will it help them come to terms with it?
6. Would group therapy be appropriate?
7. What is the role of religious figures versus the psychiatrist?
8. How will malingering be handled immediately prior to execution? Suicidality? Psychiatric hospital transfers?

ETHICAL/FORENSIC

1. What should a treating psychiatrist do if a death row inmate admits guilt in therapy while they are pursuing an appeal?
2. If an inmate is deemed incompetent to be executed, should the treating psychiatrist participate in restoration treatment?
3. Is it possible to separate restoration to competency for execution from general psychiatric treatment?
4. What should be the relationship between the treating doctor and the forensic doctor? What kind of information can be shared?
5. If the treating doctor recognizes that a patient is likely incompetent for execution, should they inform the patient's attorney? The court?
6. If a patient gives up his right to appeal and volunteers for execution, does this warrant a psychiatric investigation? Should a patient be able to ask for an early execution?

(Patients will not be completely honest in therapy if it may be used as a forensic evaluation, and doctors may be biased in forensic evaluations because of a desire to help their patients.)

Applying these principles to death row psychiatry means that a treating psychiatrist should focus specifically on treatment. However, he or she should not remain completely in the dark regarding forensic issues because he or she will be blind to certain ramifications of his or her actions that could have been avoided. For example, a comment in a progress note about an inmate's ability to understand the nature and purpose of his execution should be avoided because it is a direct assessment of the core components of competency to be executed.

On the other hand, it is important not to become obsessed with avoiding all documentation that could be relevant to competency evaluations in any way, because that would result in blank progress notes. For example, if a patient is deemed incompetent due to mental retardation, the psychiatrist's documentation of strong cognitive abilities may undermine this diagnosis, but there is no way to get around this. Removing standard parts of a mental status exam because of effects they may have if reviewed by a forensic evaluator is inappropriate.

CONCLUSION

When working on the overlap of two disciplines as unique and complex as mental health and law, certain types of dilemmas will be seen over and over. However, new situations will also never stop presenting themselves. When such clinical, ethical, and legal issues are present in death row psychiatry, the stakes are often higher. It would be prudent to have a team in place to set general policies that reflect the views of the institution and the particular laws of the state.

Every new situation is a learning opportunity, but often mistakes themselves are the best teachers. A team that meets regularly allows one person's mistake to teach lessons to many people. The more input that goes into policies over time, the better the policies will work to protect the clinical, ethical and legal interests of all those involved. This may seem like a lot of work, but the alternative could lead to much scarier situations.

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