Prison Mental Health Care: Professionalism Under Pressure

Steven Miles, MD
University of Minnesota

Conflict of Interest Disclosure

Neither the speaker nor any member of his immediate family has any personal or institutional or financial relationship with any health care lobbying group or insurance company or pharmaceutical or medical device manufacturer.

I do not represent the position of such groups on a voluntary basis.

I do not take honorariums or educational grants from such groups.

The material for this talk was entirely gathered by independent scholarship.

This presentation draws from various states' and nations' studies and policies.

It is not intended to offer legal or policy advice with regard to prisons in California.

No depiction or case study in this show is intended to depict any prison official or body.

Overview

- Fundamentals
  - Dual loyalty ethics
  - Ethics and Law

- Topics
  - Confidentiality (including telepsychiatry)
  - Undocumented Immigrants:
    - Mental health car
    - Deaths
    - Drugged deportation
  - Hunger Strikes

- Topics
  - Hunger Strikes
  - Capital Punishment
  - Castration
  - Organ and Sperm/Egg Donation
  - Research with Prisoners
  - Restraints
  - Abuse

American Psychiatric Association:
Fundamentals for Criminal Justice Practice

- The fundamental goal of a mental health service is to provide the same level of care to patients in the criminal justice process as available in the community.
- The delivery of mental health services in correctional settings requires that there be a balance between security and treatment needs. There is no inherent conflict between security and treatment.
- A therapeutic environment can be created in a jail or a prison setting if there is clinical leadership, with authority to create such an environment.
- Timely and effective access to mental health treatment is a hallmark of adequate mental health care.
- Necessary staffing levels should be determined by what is essential to ensure that access.
- It is imperative that psychiatrists define their professional responsibilities to include advocacy for improving mental health services in jails and prisons.

Dual Loyalty:
Tattered or Antiquated?

Dual Loyalty Ethics

- Subordinating medical judgment to support medical conclusions favorable to the state.
- Limiting medical treatment or information in a manner that violates the patient's human rights
- Disclosing confidential patient information to state authorities for non-therapeutic purposes
- Using medical expertise on behalf of the state to inflict harm or determine suitability for intrusions on a prisoner that are unrelated to legitimate medical treatment
  - E.g., torture, punishment, death penalty, degrading examinations, chemical and physical restraints for punishment or convenience, forensic or security examinations that are not subject to oversight or appeal by the inmate's legal counsel, etc.)
- Remaining silent in the face of human rights abuses committed against individuals and groups in the care of health professionals.
  - International Dual Loyalty Working Group. Dual Loyalty & Human Rights in Health Professional Practice. Pp. 11-50, 75-80. www.physiciansforhumanrights.org/library/documents/reports/report-2002-duelloyalty.pdf

Ethics and the Law

- A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior.
  - Principles of Medical Ethics American Medical Association

Confidentiality

Dual Responsibilities of Psychiatrists

- During ***therapeutic*** interactions, situations may arise where the physician's knowledge of the patient's condition when clinical notes or medical records are part of a larger dossier, hence not confidential to the clinical personnel in charge of the case.
- A psychiatrist in such interactions must disclose the
  - Nature of the triangular relationship
  - Absence of a therapeutic doctor-patient relationship
  - Obligation to inform a third party of information that is potentially damaging to the interests of the person under assessment.
- Psychiatrists in such circumstances should advocate for
  - Separation of records and
  - Limiting exposure of information to that which is essential for the purposes of the third party.
- Under these circumstances, the person may choose not to proceed with the assessment.
  - **Madrid Declaration on Ethical Standards for Psychiatric Practice.** World Psychiatric Association in Madrid, 1996; Hamburg, 1999; Yokohama, 2002; Cairo, 2005. (abridged)

Privacy and Confidentiality

- The health professional should insist on being able to perform medical duties in the privacy of the consultation, with no custodial staff within earshot;
  - Working Group
- A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy.
  - AMA

Confidentiality on a Sliding Scale

Security Driven Violations of Confidentiality

- I have a weapon.
- I am selling drugs.

Treatment Driven Protection of Confidentiality?

- I making making pruno.
- I am using drugs.
- I am having sex with a prison staff.
- I have a lock in a sock for protection.

J Am Acad Psychiatr and Law 2999:37:150-4

Tele-psychiatry for prisons:

- Appears to be possible and cost effective.
- Raises issues of confidentiality either by electronic or personal surveillance by non-mental health security or technical personnel oversight.

• Antonacci DJ et al. Empirical Evidence on the Use and Effectiveness of Telepsychiatry via Videoconferencing: Implications for Forensic and Correctional Psychiatry. Behav Sci and Law 2008;26:253-269.

Committee Meeting: Tele-psychiatry

The administration has asked mental health staff to develop policies to enable two mental health centers to provide tele-psychiatric services to inmates.

- One will be a pilot project with an independently contracted a community based behavioral science firm.
- One will use prison mental health personnel who will be teleconference connected to a network of prisons.

What are the central elements of your policy for

- **Confidentiality?**
- **Experience/insight?**
- **Oversight?**

Undocumented Immigrants

Lost in Prisons: Mental Illness

- Division of Immigration Health Services, the agency responsible for detainee medical care,
  - Supervises 33,000 detainees at any one time, (407,000 in any year.)
  - Does not keep statistics on mentally ill
  - Estimates that 15% are mentally ill.
    - April 2-3, 2009. http://www.nytimes.com/2009/04/03/nyregion/03detain.html

Lost in Prisons Immigrant Death

- About 10% of prisoner deaths, mostly undocumented immigrants (who die of natural causes, abuse or medical neglect) go unreported to federal lists.
- 30 (▲) of 83 deaths in prisons may have involved medical neglect or mismanagement as assessed by review by the Washington Post.

May 13, 2008. http://www.washingtonpost.com/wp-srv/nation/specials/immigration/map.html

Drugging for Deportation

Michel Shango medicated deportation to Congo in 2007.
Log filled out by a U.S. public health nurse who was his medical escort.

http://www.washingtonpost.com/wp-srv/nation/specials/immigration/index.html

Committee Meeting: Undocumented Immigrants.

- Two undocumented immigrants recently committed suicide at your prison.
  - Both were being held for property crimes.
  - Both were awaiting deportation.
  - Prison staff had assessed both as depressed and expressing suicidal intent.
- DIHS seems indifferent to
  - Reports of suicide risk.
  - Requests for funding for mental health treatment.
  - Receiving death certificates.
- Your facility has also received requests for provide tranquilizing medications for deportations of some prisoners.

The warden is asking for the outline for a mental health response to these issues.

Hunger Strikes

Declaration of Malta (abridged)

WMA-2006 http://www.wma.net/en/30publications/10policies/h31/index.html

- Physicians should talk to hunger strikers privately.
- Physicians must satisfy themselves the decision to strike is informed, voluntary and not coerced by a peer group, authorities or family members.
- Physicians may not apply undue pressure of any sort to end the strike.
- Physicians should explain how damage to health can be minimized or delayed during the strike.
- A refusal to accept certain interventions must not prejudice other aspects of medical care, e.g., treatment of infections.
- Treatment or care of the hunger striker must not be conditional upon suspending the hunger strike.
- If a physician is unable for reasons of conscience to abide by a hunger striker choice, the physician should refer the prisoner to another willing physician.
- Forced feeding is unacceptable. Feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment.
- Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.
  - (See also Working Group)

Federal Code

Title 28: Judicial Administration : PART 549—MEDICAL SERVICES

http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6d4a564f92db4502066f427fe4075 1ae2a&rgn=div6&view=text&node=28:2.0.3.3.21.5&idno=28

§ 549.60 It is the responsibility of the Bureau of Prisons to monitor the health and welfare of individual inmates, and to ensure that procedures are pursued to preserve life.

§ 549.61 An inmate is on a *hunger strike:* (a) When he or she communicates that fact to staff and is observed by staff to be refraining from eating for a period of time, ordinarily in excess of 72 hours; **[Details]**

§ 549.62 Initial referral. a) Staff shall refer an inmate who is observed to be on a hunger strike to medical or mental health staff for evaluation and, when appropriate, for treatment. **[Details]**

§ 549.63 Initial medical evaluation and management. [Details]

§ 549.65 Refusal to accept treatment.

(a) When,. . . a physician determines that the inmate's life or health will be threatened if treatment is not initiated immediately, the physician shall give consideration to forced medical treatment of the inmate.

(b) Prior to medical treatment being administered against the inmate's will, staff shall make reasonable efforts to convince the inmate to voluntarily accept treatment. Medical risks faced by the inmate if treatment is not accepted shall also be explained to the inmate. **[Details]**

(c) When, after reasonable efforts, or in an emergency preventing such efforts, a medical necessity for immediate treatment of a life or health threatening situation exists, the physician may order that treatment be administered without the consent of the inmate. **[Details]**

(d) Staff shall continue clinical and laboratory monitoring as necessary until the inmate's life or permanent health is no longer threatened.

Case Conference: Hunger Strike

- Two inmates in a medium security prison who are serving time for criminal sexual conduct with young children have announced an intent to go on a hunger strike.
- They say that they are subject to discriminatory access to gym equipment, choice of television programming and are selected for random acts of verbal abuse, harassment and physical abuse by staff and other inmates.

Capital Punishment

California

13 inmates executed since 1978.
677 inmates on death row.
17 years: average stay on death row.

Assisting Capital Punishment

- Physician participation in execution is defined as actions which would fall into one or more of the following categories, an action which:
  - would directly cause the death of the condemned;
  - would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned;
  - could automatically cause an execution to be carried out on a condemned prisoner.
- Physician participation in an execution includes, but is not limited to, the following actions:
  - prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure;
  - monitoring vital signs on site or remotely (including monitoring electrocardiograms);
  - attending or observing an execution as a physician; and rendering of technical advice regarding execution.
- Physicians should not determine legal competence to be executed.
  - **AMA Opinion 2.06 - Capital Punishment**

Assisting Capital Punishment

These acts do not constitute physician participation:

- testifying as to medical history and diagnoses or mental state as they relate to
  - competence to stand trial,
  - relevant medical evidence during trial,
  - medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or
  - medical diagnoses as they relate to the legal assessment of competence for execution;
- relieving the acute suffering of a person awaiting execution,
  - including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.
- witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity; and
- certifying death, provided that the condemned has been declared dead by another person;
  - **Opinion 2.06 - Capital Punishment**

California: Insanity Determination for execution

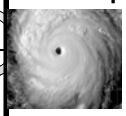
- Whenever a court enters an order appointing a day upon which a judgment of death shall be executed, the Director of Corrections shall select three alienists, all of whom must be from the medical staffs of the Department of Corrections, **to investigate his or her sanity**.
- If there is good reason to believe that such defendant **has become insane**, the warden must inform the district attorney who must file a court petition, asking that the question of his sanity be inquired into.
- The court must impanel a jury to hear such inquiry.
  - If the jury finds that the defendant is **insane**, the defendant must be taken to a medical facility of the Department of Corrections to be kept in confinement until **his reason** is restored.
  - If it is found that the defendant is **sane**, the warden must proceed to execute the judgment.

- **PENAL CODE SECTION 3700-3706** http://law.justia.com/california/codes/pen/3700-3706.html Abridged.

Use of non-prison employees

- the determination of whether an inmate is "competent for execution" should be made by an independent expert and not by any health care professional regularly in the employ of, or under contract to provide health care with, the correctional institution or system holding the inmate.
- This requirement does not diminish the responsibility of correctional health care personnel to treat any mental illness of death row inmates.
  - *Adopted by the National Commission on Correctional Health Care Board of Directors October 30, 1988*
    http://www.ncchc.org/resources/statements/competency.html

Competence to be Executed AMA



The Center of the Storm

- When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence *unless a commutation order is issued before treatment begins*.
- The task of re-evaluating the prisoner should be performed by an independent physician examiner. If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible.

- No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs.
  - *Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.*

Case Conference: You are part of a panel to determine what compliance with California law means.

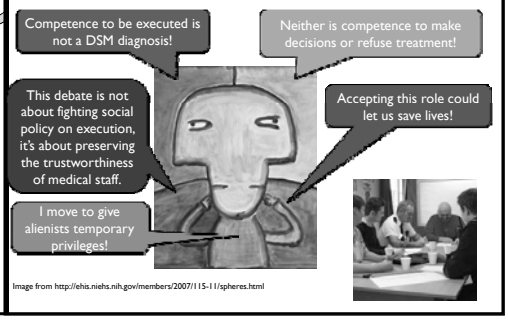


Image from http://ehis.niehs.nih.gov/members/2007/115-11/spheres.html

Castration

Chemical Castration

California Penal Code Section 645

(a) Any person guilty of a first conviction of any offense specified in subdivision (c), where the victim has not attained 13 years of age, may, upon parole, undergo [hormone treatment] ...

(b) Any person guilty of a second conviction of any offense specified in subdivision (c), where the victim has not attained 13 years of age, shall, upon parole, undergo ...

(d) The parolee shall begin treatment one week prior to his or her release from confinement in the state prison.

These protocols include a requirement to inform the person about the effect of hormonal chemical treatment and side effects that may result from it. The person shall acknowledge receiving this information.

Nothing in the protocols requires an employee of the Department of Corrections who is a physician to participate against his or her will in the administration of the provisions of this section.

Effects

- Reduces desire
- May facilitate interest in psychotherapy
- Reduces recidivision
- Increases
  - osteoporosis,
  - cardiovascular disease,
  - gynecomastia.

Clinical Ethics

- Assess for Coerced Consent
- Ensure that castration is part of a real wider package of treatment.
- Prescribe?

BMJ 2010;340:c74
See also J Amer Acad Psychiatr & Law 2005;33:16-36.

Case Conference: Castration

- A 35 year old man was convicted of a sexual assault of a 9 year old when he was 19.
- He is recently convicted and imprisoned for criminal sexual conduct with his girlfriend's child.
- A court has asked for a diagnosis of a DSM paraphilia to medically support for chemical castration after imprisonment.
- You do not find evidence to support such a disorder. Your view is that the use of drugs in this case is punitive but not therapeutic.
- What do you do?

An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist's opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment. AMA

Organ and Sperm/Egg Donation

Prisoners as Voluntary Organ Donors?

- Disease screening
  - 2.1 million health inmates;
  - Donation rate of 1% = 21,000 kidneys
  - 80,000 Americans awaiting organs;
    - 400-500 die each day
- Isolation until donation
- Payment with "time?"
  - Transplant Proc 2009;41:23-4.
  - Kennedy Inst Ethics J 2003;13:37-43.
  - Transplantation 2002;74:582-9.

Case Conference: Organ Donor

- An inmate serving a long sentence has a brother with renal failure.
- The inmate is eligible to be a kidney donor for his brother.
- He petitions to be allowed to donate.
- BOP would bear the costs of donation but not implantation.
- There are no long term extra costs from donating a kidney.

Death Row Organ Donors?

- Organ donation by death row prisoners is permissible if
  - decision to donate is made before conviction,
  - donated tissue is harvested after death and body removed from death chamber, and
  - physicians do not advise or assist modifying the execution to facilitate donation.
    - AMA Ethics Code
- What are we waiting for?
  - St. Mary's Law Journal. 34(3):687-732, 2003.

Case Conference: Artificial Insemination

- A prisoner with a 30 year old wife asks that the prison allow him to collect and freeze his sperm and to allow it to be sent to his wife who is not incarcerated.
- The couple does not want to delay conception until his release in five years because the risk of birth defects will double.
- The prisoner and his wife are willing to pay for the procedure and testing for STDs or other medical conditions.

Artificial Insemination

- The Eighth Circuit held that the policy of the Bureau of Prison prohibiting inmates from artificially inseminating other persons, did not violate plaintiffs rights.
- "We cannot subject prison regulations to strict scrutiny every time a family member is affected by the prison regulation. Incarceration necessarily deprives an individual of the freedom 'to be with family and friends and to form the other enduring attachments of normal life.' By its very nature, incarceration necessarily affects the prisoner's family.
  - 908 F2d 1395 Goodwin v. Ca Turner US 1988,

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- *Opposite finding*
  - Dickson v United Kingdom [2007] ECHR 44362/04 (Grand Chamber, 4 December 2007)

Transgender Inmates

- Correctional health staff should either be trained in transgender health care or have access to other professionals with expertise in transgender health care.
- The management of medical (e.g., hormones) and surgical (e.g., genital reconstruction) transgender issues should follow accepted standards.
- Policies that make treatments available only to those who received them prior to incarceration or that limit GID treatment to psychotherapy should be avoided.
- Transgender patients who received hormone therapy prior to incarceration should have that therapy continued without interruption pending evaluation by a specialist, absent urgent medical reasons to the contrary.
- Transgender inmates who have not received hormone therapy prior to incarceration should be evaluated by a qualified health care provider to determine their treatment needs for hormone therapy and/or sex reassignment surgery on a case-by-case basis.
- Psychotherapy or attempts to alter gender identity should not be employed.
- In matters of housing, recreation, and work assignments, custody staff should be aware that transgender people are common targets for violence. Appropriate safety measures should be taken regardless of whether the person is placed in male or female housing areas.
- Transgender inmates receiving hormone therapy should receive a sufficient supply upon release to last until a community provider assumes care.
- ***National Commission on Correctional Health Care Board of Directors October 18, 2009 (Abridged)***

Research with Prisoners

Research

- The health professional should not engage or participate in any form of human experimentation amongst prisoners, unless the research will provide significant health and other benefits for prisoners and facilitate promotion of their human rights.
  - Working Group
  - See also *National Commission on Correctional Health Care Board of Directors*
    October 18, 2009

California Prisoner Research

A prisoner shall be deemed to have given his informed consent if

Consent is given without duress, coercion, fraud, or undue influence.

Informed of the potential risks and benefits.

Informed orally and in writing of:

(1) research procedures, their purposes, and which are experimental.

(2) attendant discomfort and risks reasonably to be expected.

(3) alternative biomedical/behavioral research procedures that might help the subject.

(4) the information sought by the experiment.

(5) the expected recovery time after completion the experiment. \

(6) the manner in which the prisoner may obtain prompt treatment for any research-related injuries.

(7) right to discontinue at any time without prejudice.

The amount of such remuneration shall be comparable to that which is paid to nonprisoner volunteers in similar research.

http://law.justia.com/california/codes/pen/3521-3523.html (Abridged)

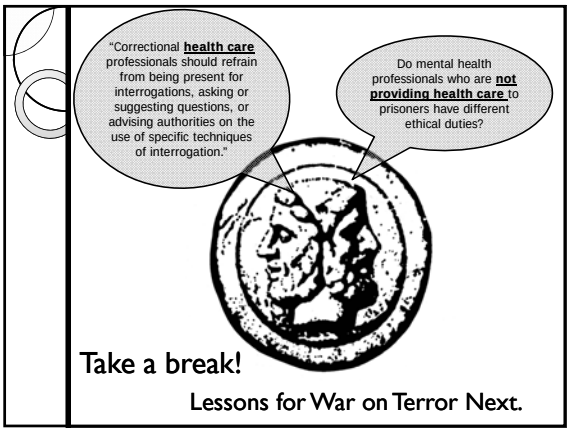
Restraints

Restraints

- The health professional should not perform any medical duties on shackled or blindfolded patients, inside or outside the custodial setting.
- The only exception should be in circumstances where, in the health professional's judgment, some form of restraint is necessary for the safety of the individual, the health professional and/or others, and treatment cannot be delayed until a time when the individual no longer poses a danger.
  - In such circumstances, the health professional may allow the minimum restraint necessary to ensure safety.
  - Working Group

Prisoner abuse

- Correctional health care professionals should not condone or participate in cruel, inhumane, or degrading treatment of inmates.
- When such abusive treatment is either witnessed or suspected, they should identify and report such incidents to the appropriate authority.
- Correctional health care professionals should refrain from participating, directly or indirectly, in certifying inmates as medically or psychologically fit to be subjected to abusive treatment.
- Correctional **health care** professionals should refrain from being present for interrogations, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation.
- Correctional health care professionals should refrain from gathering health information for forensic purposes or sharing confidential health information or its interpretation to authorities for use in cruel, inhumane, or degrading treatment of inmates.
- Correctional health care professionals should abstain from being used as an instrument of their employer to weaken the physical or mental resistance of inmates.
- *National Commission on Correctional Health Care. October 14, 2007*



Steven Miles, MD
University of Minnesota
Slides available on request:
Miles001@umn.edu