

Exploring ethical, legal, and professional issues with the mentally ill on death row

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World opinion on capital punishment versus U.S. practice

In order to establish an appreciation of the ethical dilemmas involving current execution practices in the United States, it is essential to understand our views in contrast to the international position on capital punishment practices. In 1999, a worldwide moratorium on executions was passed by the United Nations Human Rights Commission. The resolution suggested that those countries that have not abolished the death penalty restrict its use to a limited number of offenses and discontinue the execution of juveniles (Amnesty International, 2005). Further, only 76 of 196 countries retain use of the death penalty. Ironically, the United States shares the practice of capital punishment not with nations who are considered allies or similar in belief systems, but with countries such as China, Cuba, Iran, Iraq, Saudi Arabia, Kuwait, and Nigeria, to name only a few. Moreover, 94% of the 3800+ executions in 2004 were in the United States, Vietnam, and Iran (Amnesty International, 2005). In mid 2003, the United States (the only country other than Somalia) refused compliance with the *United Nations Convention on the Rights of a Child* because the treaty required that juvenile offenders could not be killed (Prejean, 2005).

Clearly, America's practices conflict with most world opinion regarding the death penalty. Although the United States has not yet discontinued use of this form of punishment, international influences may promote changes in the near future. According to Dieter (2003), there are at least three prominent reasons for the anticipated recognition and implementation of international directives in the United States: (1) there is a growing need for international cooperation and respect for laws in other democracies, (2) international human rights issues such as with extradition, foreign terrorists, and disputes in relation to the execution of foreign nationals from other nations such as Paraguay, Germany, and Mexico have become more frequent, and (3) at present, views are almost unanimous in condemning use of the death penalty in certain groups, such as juveniles. New developments in trends toward abolishment of the death penalty are being considered with the emergence of new information and concerns, including but not limited to racial disparities, wrongful convictions, prediction of future dangerousness, jury decision-making, public opinion, costs, and methods of execution (Acker et al., 2003). Currently, mentally ill or retarded inmates are the only groups legally protected from capital punishment in the United States.

Law versus practice

In *Ford v Wainwright* (1986), the Supreme Court ruled the Eighth Amendment proscription against cruelty prohibits killing the insane but provided no definition of insanity. As a consequence, mental illness continues to be ignored and often times these individuals fall through the cracks of the law and onto death row. According to the National Mental Health Association (NMHA, 2005), common mental illnesses seen on death row include Bipolar Disorder, Schizophrenia, Post-Traumatic Stress Disorder, and Schizoaffective Disorder. It is estimated that at least 10% of U.S. death row inmates are mentally ill (NMHA, 2005).

One example is Kelsey Patterson who was executed in Texas on May 18, 2004, despite his suffering with severe paranoid schizophrenia. He was diagnosed 10 years prior to his offense and for many years was declared mentally incompetent to stand trial. The day before his execution, the Pardon and Paroles Board met and recommended clemency to the governor, which was denied (Death Penalty Information Center, 2005).

Another case is Sammy Perkins who was executed by lethal injection in North Carolina on October 8, 2004. He was the 933rd murderer to be executed in the United States and the 32nd to be executed in North Carolina since 1976. He was diagnosed with Bipolar Disorder after his offense and was previously unaware that the symptoms that he had been living with were treatable. A jury never heard about his mental illness (Clark Prosecutor, 2005).

In 2002, *Atkins v Virginia* declared it unconstitutional to execute mentally retarded persons. The ruling was one that the United Nations Commission on Human Rights had called for on numerous occasions (Dieter, 2003). Prior to *Atkins v Virginia*, 35 mentally retarded prisoners were executed in the United States. However, despite the law and an improvement in the situation, mentally retarded offenders continue to be sentenced with capital punishment (Prejean, 2005).

A discussion of ethical issues

How do the mentally handicapped end up on death row?

While there are many aspects of executing mentally ill or mentally retarded prisoners that deserve debate, there is one obvious question that must be addressed first. Why are the criminally insane or mentally retarded in prison, particularly on death row, rather than in psychiatric treatment facilities? The answer is not simple.

It should be noted that there are safeguards within the system that serve to "ensure that the serious mental

health needs, including those related to developmental disability and addictions are identified." (NCCHC, 2005). Every inmate should be screened and evaluated for mental conditions upon booking to the detention facility. The standard is clearly stated by the National Commission on Correctional Health Care (NCCHC, 2005). This ensures that the inmate receives proper psychiatric treatment, as well as documentation of the diagnosis prior to judgment and/or sentencing. The process should eliminate errors that result in improper sentencing of a detainee.

However, many state laws include a condition that if the mentally ill prisoner on death row is restored to sanity through therapy or medications, the state can then execute him. Furthermore, on February 10, 2003, a federal appeals court ruled that administering psychotropic medications to an unwilling death row inmate was not a violation of the US Constitution (Hausman, 2003). Clearly, the 1986 ruling against executing mentally ill inmates in *Ford v Wainwright* has been buried under exceptions and loopholes in the interest of death penalty supporters.

American culture plays a significant role in reasons for ambivalence regarding the management of mentally handicapped who may have committed serious crimes. According to Phoebe Ellsworth, Distinguished University Professor of Law and Psychology and expert on death penalty issues, most Americans are now in favor of capital punishment (Wadley, 2004).

A closer look at reasons for this may be of profound concern. Studies conducted by Barkan and Cohn (Broom, 2004) indicate that racial prejudices are a major reason for such overwhelming support of the death penalty. The studies revealed that more than 80% of those on death row are African-American or Hispanic. After four studies that explored reasons for supporting the death penalty, results consistently showed a "strong link between punitive attitudes and racial prejudice." The studies conclude that law-makers should not base decisions on public opinion if they are tinged by racial prejudice. It is possible that empathy for people who are different and commit crimes may be much less than for those who are better understood.

Another view (Zimring, 2003), suggests that a highly diverse country will inevitably have highly diverse cultural values and division concerning decisions about what is right or wrong. Zimring suggests that the death penalty violates our legal system's highest principles of fairness and due process. Conversely, some citizens see the executions as a means of local control and a safeguard to the public. His observation that most executions occur in the southern states where lynching was most common is worthy of some consideration. Is it not the same horrible form of punishment if by electrocution or lethal injection? Is the outcome and principle of the action any

different from a lynching that most would consider barbaric in today's culture?

A legal analysis by Zimring (1999) suggests that there is an evident and remarkable conflict between the operational needs in a system that performs executions and the fundamental principles and procedures of the American legal system. If capital punishment is to be a normal state of conduct in our country, then our legal system and social system must redefine and "reimage" the basic principles of fairness in criminal justice. Thus, one might conclude from the stated arguments that the conflicting nature of the law when dealing with the mentally handicapped is a product of diversity of opinion, ignorance concerning mental diagnoses, insecurity with a need to feel safe, and legislation torn between the fundamental values of our forefathers and pressure to change (even if without a conscious decision to do so) our principles based on current public opinion and levels of violence in America today.

To treat or not to treat?

The issues are particularly complex for psychiatric providers who work on death row. Correctional health care organizations responsible for setting standards and guidelines for inmate treatment, such as the NCCHC and the American Correctional Health Services Association (ACHSA), state that only if an inmate is a danger to himself or others, can he or she be forcibly, but humanely, treated with medication or other necessary interventions (NCCHC, 2005). Moreover, both agree that inmates have a right to refuse treatment of any kind, unless, of course, dangerous behavior warrants involuntary treatment. However, neither of these correctional facility organizations addresses forced treatment to restore sanity in death row inmates. This is not surprising since, in theory, there should be no mentally ill prisoners on death row. Although the situation occurs regularly, and new twists in the law provide avenues to execute the mentally ill, the problem is one that is not discussed formally.

There are many documented cases of inmates who have been forced to take psychotropic medications and were subsequently executed. An example is Charles Singleton of Arkansas who was forcibly medicated to restore his sanity and consequently executed in 2004. An appeal to the U.S. Supreme Court resulted in a vote of 6 to 5 in favor of Arkansas' contention that it should be allowed to medicate Singleton against his will. This case has been cited and discussed by courts and the medical community since its occurrence. American Psychiatric Association President, Paul Appelbaum, M.D., stated that he disagreed with the ruling and that, "Physicians violate their ethical obligations as healers when they treat condemned

prisoners for the purpose of restoring competence to be executed" (Hausman, 2003).

It is essential to recognize the ethical predicament for psychiatric practitioners caring for death row inmates. If the provider treats the prisoner, and the prisoner is "cured," he will be sentenced to death. Even if the client is voluntarily treated, due to cognitive disability or altered thought processes, the outcome is not in the best interest of the inmate. Participating in such practice is a clear violation of the Code of Ethics, which is a key element of a provider's decision-making process from the first day of training.

Professional and correctional organizations alike are in agreement as to health care providers' involvement in the execution process, unquestionably opposing their participation in capital punishment. The American Medical Association (AMA), American Nurses Association (ANA), and the American Public Health Association released a joint statement indicating that involvement in executions is a serious violation of professional ethical standards. The release (ANA, 1996, p. 2) states that since "these ethical codes are integral parts of the state medical, nursing, and other health professional practice and licensing acts, participation in execution violates state law." Furthermore, correctional health care organizations observe the same outlook. The ACHSA published a Code of Ethics specific to detention facilities. The code states that health care providers "are not to be involved in any aspect of the death penalty" (ACHSA, 1990). The idea calls for good judgment and professional responsibility. Is restoring the sanity of a mentally ill inmate for the purposes of imposing the death penalty considered involvement in the execution process?

The Maturana case plainly depicts a psychiatric provider's ethical difficulty when treating death row inmates. Claude Maturana of Arizona was declared mentally incompetent related to severe psychosis. He was then transferred to a state psychiatric hospital, where his psychiatrist treated him, easing his distress but not completely alleviating the symptoms. The psychiatrist adhered to medical ethical codes and refused to medicate Maturana adequately enough to restore his sanity. According to the attorney general, Arizona law stated that the psychiatric institution must find a "willing" physician. No one came forward until they expanded to a nationwide search. Nelson Bennett, M. D., from Georgia, found Maturana competent and claimed that he did not require pharmacological intervention (Freedman, 2001).

The concept of forcing treatment in this population brings forth many questions to consider. Are psychiatric care providers who work with condemned prisoners obliged to respect choices, protect the individual, and support self-governance? Are detained criminals entitled

to the same degree of autonomy as any other patient? Is the mental condition of the inmate after treatment relevant if he were ill at the time of the offense? What is the definition of “insane” and which mental conditions may result in the dismissal of criminal responsibility? Should the courts be able to order involuntary treatment on a case-by-case basis?

Conclusions

Unmistakably, ethical issues with psychiatric patients on death row are a web of morality, politics, and personal values. As with caring for any other patient, providers of mental health care to inmates must consider the best outcome for the client. The fate of the inmate is influenced by the legal system, the media, public opinion, and those who provide care in the system, all of whom may have conflicting views and values.

In terms of the mentally disabled inmate, it has recently been recognized that they should not be considered for the death penalty. Evolution in America's perspectives on capital punishment have progressed to a mere legal acknowledgment that execution of these individuals is cruel and unusual punishment. Nevertheless, in practice, this population of inmates continues to be sentenced with the ultimate punishment. Each case in each state may be viewed differently by the judge or jury; therefore, the sentencing of these individuals varies, regardless of the federal law. Thus, the fate of the mentally handicapped within the court system continues to be a conflict between medical ethics, legal statutes, and public beliefs.

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