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CNS Intervention in the Courtroom: An Ethical Evaluation of the Rehabilitative Potential of SSRIs

Khayla Black
New York University Shanghai

Introduction

In recent years, advancements in neuropharmacology have introduced the possibility of altering target behaviors through the use of drugs such as selective serotonin reuptake inhibitors (SSRIs) and antiandrogens. Though the use of SSRIs is not yet prominent is the U.S. legal system, eight states have incorporated antiandrogens into their rehabilitation plans for criminal offenders; in many cases, compliance with treatment plans has been established as a prerequisite for release from incarceration. Numerous studies have suggested that SSRIs, such as Fluoxetine, have an anti-aggressive effect (Coccaro & Kavoussi, 1997; Fava et al., 2011). Thus, SSRIs have the potential to decrease crimes of aggression in a comparable manner to the reduced chance of recidivism that is predicted with the use of antiandrogens. The comparable capabilities of SSRIs and antiandrogens, considered alongside the success of SSRIs in influencing aggression and impulsivity, necessitates an evaluation of the ethical dimensions of their potential for integration into the courtroom.

In this essay, I argue that establishing selective serotonin reuptake inhibitors (SSRIs) as a precursor to release from incarceration under current policy would cause a deprivation of mental integrity, resulting in an incomplete attempt at rehabilitation. I aim to establish a definition of mental integrity and evaluate, from a principlist perspective, how drastically it is harmed by the use of medical correctives. I end by claiming that a change in policy could complete the rehabilitative attempt, allowing for successful integration of SSRIs into the U.S. legal system; incorporating behavioral interventions into treatment plans could compensate for the harm inflicted on mental integrity.

Current Policies on Medical Correctives

Currently, antiandrogens are the most prominent form of medical correctives in the U.S. legal system. Eight states have passed laws establishing policies detailing the use of medroxyprogesterone acetate (MPA) to treat sexual offenders (Norman-Eady, 2016). According to Mayo Clinic (2019), MPA is an artificial hormone used in females to regulate menstruation and treat excessive uterine bleeding; in males, it is used as an antiandrogen with the aim of significantly reducing testosterone levels. The severity of offense that would necessitate this treatment differs between states, but is commonly established as a repeated offense and/or offense to a minor under age 13. Similarly, conditions of MPA implementation differ across states. While California legislation specifies that MPA treatment is mandated as a prerequisite to parole, the state of Wisconsin has established a policy that allows for recommendation of the treatment, but does not permit denial of parole upon refusal of treatment (CA Penal Code § 645, 2018; Wisconsin Statutes § 301.047, 2019). Similar to California, Florida statutes mandate

treatment be completed upon recommendation by a medical health professional (Florida Statutes § 794.235, 2018). Interestingly, legislation in Louisiana asserts that recommended treatment for sexual offenders may include the utilization of MPA treatments or behavioral interventions, but does not specify opportunity for integration between the two forms of intervention (LA Rev Stat § 15:538, 2018). When decided upon, MPA treatments begin prior to release (generally one week) and are continued until deemed unnecessary by the Department of Corrections (DOC); refusing or discontinuing treatment can often lead to fines or reincarceration (Norman-Eady, 2016). To proceed with evaluating the potential implementation of SSRIs into the courtroom, I propose a generalization of current policies to serve as a reference throughout the remainder of the essay. In referring to "current policy", I reference one which operates under the following conditions:

1) A sentence is predetermined by legal personnel.
2) Repeated offenders or first time offenders who have offended a minor under age 13 are required to comply with treatment as a prerequisite to parole.
3) Treatments will be administered beginning one week prior to release and will continue until deemed unnecessary by the DOC.

Mental Integrity

The use of SSRIs involves manipulation of the mind, consequently leading to a violation of the offender's mental integrity. For the purpose of this essay, I adopt and maintain Lavazza's definition of mental integrity, denoting it as the individual's "mastery of mental states and brain data so that, without consent, no one can read, spread, or alter such states and data in order to condition the individual in any way" (2018, p.4). To see why medical correctives inevitably deprive the offender of mental integrity, consider an example set forth by cognitive neuroscientist Martha Farah (2002). Suppose that criminal A has been incarcerated for a crime of aggression, and that anger management classes have been assigned as a condition of probation. On the other hand, criminal B, who committed a comparable offense, is required to take Fluoxetine as a condition of probation. Individual A is able to attend the classes, consider the advice and instruction provided, and decide which tactics to implement into his life. Similarly, he is free to decide against using certain methods. However, individual B is deprived of such a choice. Individual B has no control over the influence that Fluoxetine has on his mental state. As Farah concludes (2002), there is no opportunity for him to retain control over his mental capabilities and accept or resist effects in the same way that individual A is able to. This inability to resist changes demonstrates how an irresistible conditioning of the individual's mental state accompanies the use of medical correctives.

A Principlist Perspective on Harm to Mental Integrity

Examining the harm to mental integrity from a principlist perspective will reveal the severity of the harm inflicted. Principlism is founded on four precepts: autonomy, justice,

nonmaleficence, and beneficence. With these values in mind, we can examine the repercussions of the deprivation of autonomy that is inflicted by medical correctives.

In explaining how to respect autonomy, philosopher Thomas Beauchamp maintains that it is necessary that "autonomous actions are not subject to the controlling constraints of others," (2006, p. 4) while emphasizing that healthcare professionals are obligated to do everything in their power to preserve autonomous capabilities. For the purpose of this essay, I will limit discussion of offenses to those that result from medically unremarkable behavior. Thus, there is no biological anomaly hindering the offender's ability to understand, intend, or make decisions, as would be necessary to justify a claim towards lack of autonomous capability. Offenders retain capacity necessary to be deemed autonomous until the point at which they begin to take corrective medication. That is not to say that individuals who take medical correctives do not retain decision making capacity. However, if we refer back to Farah's example (see "Mental Integrity"), we see that there is some degree of mental freedom that individual B is deprived of that A maintains. Though it may range anywhere from minimal to drastic, the use of medical correctives deprives an individual with intact mental capacity of their autonomy.

Unlike autonomy, the principle of justice does not demonstrate a direct harm to mental integrity; however, it does highlight an unavoidable injustice present when manipulating mental integrity. For an act to be deemed as just, "equal individuals must be treated equally" (Beauchamp, 2006, p.6). However, the use of psychiatric drugs results in a degree of uncertainty as to how the central nervous system will be influenced across different individuals. This being the case, it is impossible for judges and health care professionals to ensure that offenders in equivalent situations will be comparably affected. Not only does this underscore the injustice of medical correctives, but it raises another question. What if the medications are ineffective in influencing the desired behavior in some individuals? In this case, the medications are unsuccessful in rehabilitating the offender as well as ineffective in decreasing the probability of recidivism.

Finally, we can consider nonmaleficence and beneficence. Though these are defined as two separate principles, I find it sufficient for the purpose of this essay to address them as one entity. While nonmaleficence draws upon the common healthcare notion "above all, do no harm," beneficence asserts that the goal of the health care provider(s) is not to do no harm, but to maximize positive outcomes (Beauchamp, 2006). One can argue that medical correctives are the optimal solution to release from incarceration; they both (ideally) treat the offender and benefit society by lowering the chance of recidivism. However, I argue that a similar result can be achieved without the deprivation of mental integrity that results from the prescription of medical correctives alone. A more elaborate treatment plan with behavioral interventions to accompany correctives may have the potential to compensate for their depriving nature. I will explore this notion further in the following section, concluding that, since an option which decreases harm yet results in the same benefits does exist, prescribing medical correctives alone would result in an unnecessary degree of deprivation. This would be inconsistent with both the notions of

nonmaleficence and beneficence. This, taken in coordination with the other harms discussed, attests to the severity of harm done to mental integrity.

Interventions as a Means of Rehabilitation

Current policy on medical correctives demonstrates an incomplete attempt at rehabilitating the offender. Let rehabilitation be defined as "improvement of the character, skills, and behaviour of an offender through training, counselling, education, etc., in order to aid reintegration into society" ("rehabilitation", 1870). Though the use of SSRIs to decrease behaviors such as aggression and impulsivity should be considered a behavioral improvement, it is not accompanied by an attempt to aid the offender in reintegrating into society. The use of medical correctives deprives the offender of their autonomy and leaves the offender susceptible to negative repercussions of the medication. Additionally, the offender is not provided with guidance that would allow successful utilization of inflicted change or support in the event the medication does not influence the offender as predicted. These issues highlight the obstacles put forth that prevent successful reintegration, emphasizing the incompleteness of the rehabilitative attempt.

The current lack of rehabilitation in present policy does not invalidate the rehabilitative potential of said policy. If medications could be prescribed without inflicting extensive harms on mental integrity, treatment plans would prove sufficient in aiding reintegration, similar to training, counseling, and education (suggested as appropriate in the definition). As Farah explains (2002), behavioral interventions such as anger management allow offenders to process suggested behaviors and choose how to integrate them into their lives in such a way that allows them to handle urges (ie: aggressive impulses). Pairing behavioral interventions such as therapy with prescribed medical correctives would afford offenders the opportunity to utilize changes induced by correctives in a productive manner, decreasing the likelihood of repeated offense. Along with this, involvement of a medical health professional would allow for a close evaluation of the offender; in this case, relevant professionals would be well equipped to notice and address undesired side effects. Mandating that medical correctives be accompanied by behavioral interventions could compensate for the deprivation to mental integrity and would aid in reintegration, demonstrating a complete rehabilitative attempt.

Future Directions

I have argued that incorporating SSRIs into treatment plans for offenders under current policy represents an incomplete attempt at rehabilitation. This is not to say that SSRIs lack rehabilitative potential, but that a shift in policy is necessary if they are to be successfully integrated into the legal system. The harm inflicted on mental integrity is severe enough to result in a deficit that would need to be addressed prior to an establishment of SSRIs as a rehabilitative treatment plan. The implications of this information are critical in determining acceptable ways for legal and mental health personnel to address offenders for crimes, such as those of

aggression. Moving forward, it is imperative that attempts are made to complete rehabilitative efforts and productively utilize change inflicted on offenders. It is essential to maintain the idea that this is not only the most ethical approach but also the most effective in ensuring successful reinsertion of offenders into society.

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