Forensic psychiatry: contemporary scope, challenges and controversies

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Forensic psychiatry is the branch of psychiatry that deals with issues arising in the interface between psychiatry and the law, and with the flow of mentally disordered offenders along a continuum of social systems. Modern forensic psychiatry has benefited from four key developments: the evolution in the understanding and appreciation of the relationship between mental illness and criminality; the evolution of the legal tests to define legal insanity; the new methodologies for the treatment of mental conditions providing alternatives to custodial care; and the changes in attitudes and perceptions of mental illness among the public. This paper reviews the current scope of forensic psychiatry and the ethical dilemmas that this subspecialty is facing worldwide.

Key words: Forensic psychiatry, mental health legislation, mental health services, ethical controversies

From an obscure and small group of psychiatrists who dedicated their efforts to the study of mental conditions among prisoners and their treatment, and who occasionally would appear in courts of law, forensic psychiatrists have now developed into an established and recognized group of super-specialists, an influential group that is transforming the practice of psychiatry and that has made deep incursions into the workings of the law. This status has not come without misgivings about the basic identity of forensic psychiatry and concerns about its utility and its ethics.

Modern forensic psychiatry has benefited from four key developments: the evolution in the medico-legal understanding and appreciation of the relationship between mental illness and criminality; the evolution of the legal tests to define legal insanity; the new methodologies for the treatment of mental conditions that provide alternatives to custodial care; and the changes in public attitudes and perceptions about mental conditions in general. These four moments underlie the expansion recently seen in forensic psychiatry from issues entirely related to criminal prosecutions and the treatment of mentally ill offenders to many other fields of law and mental health policy.

SCOPE AND CHALLENGES

The subspecialty of forensic psychiatry is commonly defined as "the branch of psychiatry that deals with issues arising in the interface between psychiatry and the law" (1). This definition, however, is somewhat restrictive, in that a good portion of the work in forensic psychiatry is to help the mentally ill in trouble with the law to navigate three completely inimical social systems: mental health, justice and correctional. The definition, therefore, should be modified to read "the branch of psychiatry that deals with issues arising in the interface between psychiatry and the law, and with the flow of mentally disordered offenders along a continuum of social systems". Forensic psychiatry deals with issues at the interface of penal or criminal law as well as with matters arising in evaluations on civil law cases and in the development and application of mental health legislation.

Penal law

Worldwide, a wider understanding of the relationship between mental states and crime has led to an increased utilization of forensic experts in courts of law at different levels of legal action.

On entering into the legal system, three major areas need consideration: fitness to stand trial, insanity regulations and dangerousness applications. The major developments on the issue of fitness to stand trial pertain to rulings that defenders found not fit to stand trial are sent to psychiatric facilities, with the expectation that their competence to be tried is to be restored: the question for clinicians revolves on what parameters to use to predict restorability of competence, which should be based on an adequate response to treatment (2). Insanity regulations pertain to legal tests used to decide whether the impact of mental illness on competence to understand or appreciate the nature of a crime could be used to declare an offender "not criminally responsible because of a mental condition", "not guilty by reasons of insanity" or any other wording used in different countries. Applications to declare a person a "dangerous offender" usually demand a high level of expertise on the part of forensic experts, who are expected to provide courts with technical and scientific information on risk assessment and prediction of future violence.

Once an offender has been adjudicated, a major task for forensic psychiatrists is to gauge the level of systems interface in relation to different types of receiving and treating institutions. Hospitals for the criminally insane, mental hospitals for the civilly committed patients, penitentiary hospitals for mentally ill inmates, as well as hospital wings in local jails, are all part of the mental health system, and their interdependency has to be acknowledged for purposes of system integration and budgeting (3). How mental patients are managed in prisons is also a major matter of concern. Table 1 shows some of the currently available alternatives.

Finally, on exit from the legal-correc-

tional system, forensic psychiatrists are expected to provide expert knowledge on matters such as readiness for parole, predictions of recidivism, commitment legislation applicable to exiting offenders, and the phenomenon of double revolving doors for the mentally ill in prisons and hospitals.

Civil law

Psychiatrists and other mental health specialists are often required to conduct assessments with a view to determine the presence of mental or emotional problems in one of the parties. These types of assessments are needed in multiple situations, ranging from examinations to specify the impact of injuries on a third party involved in a motor vehicle accident, to evaluations of the capacity to write a will or to enter into contracts, to psychological autopsies in order to assess testamentary capacity in suicidal cases or sudden death, or evaluations for fitness to work and, of late in many countries, evaluations to determine access to benefits contemplated in disability insurance. In most of these situations, the issue at hand is a determination of capacity and competence to perform some function, or the evaluation of autonomous decision making by impaired persons. A determination of incapacity leading to a finding of incompetence becomes a matter of social control that is used to legitimize the application of social strictures on a particular individual. This imposes on clinicians an increased ethical duty to make sure that their decisions have been thoroughly based on the best available clinical evidence.

Ordinarily, there is a presumption of capacity and, hence, that a particular person is competent. A person is assumed to be competent to make decisions, unless proven otherwise (4). The presence of a major mental or physical condition does not in and of itself produce incapacity in general or for specific functions. In addition, despite the presence of a condition that may affect capacity, a person may still be competent to carry out some functions, mostly because the capacity may fluctuate from time to time, and because competence is not an all or none concept, but it is tied to the specific decision or function to be accomplished. In addition, a finding of incapacity should be time-limited; that is, it will have to be reviewed from time to time. For example, a stroke may have rendered a person incapacitated to drive a motor vehicle and hence the person will be deemed incompetent to drive, but the person could still have the capacity and be competent to enter into contracts or to manage personal financial affairs. With time and proper rehabilitation, the person may be able to regain capacity and competence to drive. Ordinarily, a person has to consent to an assessment of incapacity or a legal order has to be obtained to make the person cooperate to the assessment or to proceed to collect information otherwise. It is advisable to use a screening test of capacity and to do a full assessment only if the person fails the screening test. This will prevent imposing an onerous burden on the person subject of the assessment if the screening test is easily passed.

Table 1 Models for the delivery of mental health care to mentally disordered offenders

Ambulatory treatment within prison Mental patients remain with other inmates in the regular cells and tiers of the prison and come for visits to the infirmary during psychiatric clinic
Special wing within the prison Mental patients are transferred to this wing for the duration of the episode or duration of their incarceration
Specialized security hospitals (penitentiary hospitals) Mental patients or those with special criminal pathology such as sexual offenders are transferred out to these hospitals, usually for the duration of their incarceration
Contractual arrangements with outside psychiatric facilities Mental patients are transferred out to these hospitals or psychiatric units for the duration of the episode
Forensic community corrections Every effort is made to prevent that mental patients enter the prison system or, if released from prison, to ensure that they not go back

Mental health legislation and systems

The double revolving door phenomenon, whereby mental patients circulate between mental institutions and prisons, has made forensic psychiatrists deeply aware of the interactions in the mental health system and the links between this system and the justice and correctional systems. By virtue of their involvement in legal matters, forensic psychiatrists have developed a major interest in the drafting and application of mental health legislation, especially on the issues of involuntary commitment, that in many countries is based on determination of dangerousness as opposed to just need for treatment, of management of mentally ill offenders and of legal protections for incompetent persons (5). Given that one major area of their expertise is the assessment of violence and the possibility of future violent behaviour, forensic psychiatrists are usually called upon to make decisions on risk posed by violent civilly committed patients.

There is a close interaction between legislation, development of adequate mental health systems and delivery of care, whether in institutions or in the community. Mental health legislation with overly restrictive commitment clauses even for short-term commitment, deinstitutionalization resulting from the closure of old mental hospitals, changes in health care delivery systems towards short admissions to general psychiatric units and subsequent treatment in the community, and the large number of mental patients that end up in jails, have created in many countries a sense that the mental health system is adrift. The growth of forensic psychiatry may be due to changes in the

law and to a more liberal acceptance of psychiatric explanations of behaviour, but a more immediate reason is the large number of mental patients in forensic facilities, jails, prisons, and penitentiaries. Failures of the general mental health system may, therefore, be at the root of the growing importance of forensic psychiatry (6).

One reason that has been most commonly advanced to explain the large number of mental patients surfacing in the justice/correctional system is the policy of deinstitutionalization that governments have implemented over the past fifty years. In general, deinstitutionalization refers to legislative decisions to close large mental hospitals and resettle patients into the community, providing short admissions to general hospital psychiatric units, outpatient treatment options, psychosocial rehabilitation, alternative housing and other community services. Sometimes, however, these decisions did not respond to any planning, or any assessment of the needs of those patients that were going to be resettled, or deinstitutionalized. Neither was there a clear idea about the nature of services to be provided, or the characteristics of the communities where patients were going to be relocated. The decisions, therefore, were mostly made on rhetorical and political beliefs, rather than on proper scientific reasoning.

The idea and policies of deinstitutionalization have been both praised and vilified. To some, deinstitutionalization is an enlightened, progressive and humane set of policies that has placed the needs of the mentally ill front and centre in many communities. In this regard, deinstitutionalization has been very effective. Deinstitutionalization should be credited with an increase in the involvement of patients in their own care and rehabilitation, it has raised questions that challenge the therapeutic nihilism rampant in a previous era, it has increased the visibility of mental patients in the community and in general hospitals and academic centres, it has allowed for a better understanding of the disease process which, previously, had been distorted by the negative effects of prolonged institutionalization, it has provided an impetus for research and learning, and it has increased awareness of the human and civil rights of mental patients.

On the other hand, deinstitutionalization has also been credited with a host of negative effects. Legally, along with legal activism, deinstitutionalization has been blamed for giving impulse to litigation and costly over-legalization and over-regulation of psychiatric practice (7). Socially, a series of pernicious effects have impacted directly on the fate of the mentally ill in the community. These have included reports of "revolving door patients" (those patients in need of repeated and frequent admissions) (8), and the rise among the homeless populations in that at least 30% among them are chronically mentally ill persons (9). Even when housing is available, it is often in rundown tenements in inner cities or psychiatric ghettos of large urban centres, where dispossessed and confused mental patients walk about in a daze talking to themselves, and where they are easy victims of robbery, rape, abuse, and physical violence. Some simply die of exposure in the streets in frigid winter nights (10). Deinstitutionalization has also been blamed for the criminalization (11) and the transmigration of mental patients from the mental health system to the justice/correctional system and for violent behaviour displayed by some mental patients in the community.

The most pointed criticisms to deinstitutionalization, however, are no longer aimed at the idea of resettling the patients back into their communities, but about how the idea has been implemented. Whether because of financial constraints or shortsighted administrations, the fact is that, in many communities, mental hospitals have been emptied faster than the development of adequate community resources and community alternatives as they were envisioned in the original policies.

These unfortunate after-effects of deinstitutionalization should be counteracted with the realization that treatment alternatives to custodial care exist in the form of better medications with enhanced efficacy and effectiveness, that are becoming widely available, and psychosocial treatment strategies, that are also providing new proven ways for management of mentally ill persons in the community (12). In this respect, the development of mental health courts in some countries, diversion alternatives to imprisonment, assertive community treatment and intense case management modalities, as well as the use of community treatment orders (13), along with better policies in housing, point toward a social move to resolve the inequities of deinstitutionalization in order to stabilize community tenure for the mentally ill. At the same time, evaluations of anti-stigma programs seem to indicate that some of these initiatives are helping in changing public attitudes toward mental illness (14) and increasing awareness about the human rights issues in the treatment and management of the mentally ill in many countries (15,16).

ETHICAL CONTROVERSIES

Because of its dual role in medicine and in law, the practice of forensic psychiatry is fraught with ethical dilemmas worldwide. A forensic psychiatrist is first of all a clinician with theoretical and practical knowledge of general psychiatry and forensic psychiatry, and experience in making rational decisions from a clearly stated scientific base. In law, forensic psychiatrists must know the legal definitions, the legal policies and procedures, the legal precedents relating to the question or case at hand (17). Forensic psychiatrists must have knowledge of courtroom activity and must possess an ability to communicate their findings clearly and to the point and to do so under the difficult situation of cross examination. The double knowledge in psychiatry and law defines the subspecialty of forensic psychiatry and provides the ethical foundations for its practitioners. This double knowledge should be reflected from the very beginning in the way the forensic psychiatrist first agrees to get involved in an evaluation, the way the forensic psychiatrist approaches the person to be evaluated, and the

caveats that have to be provided. At this stage, the most important issue for the forensic psychiatrist is to make sure that the person subject of the evaluation is not misled into believing that, because the psychiatrist is a medical doctor, the relationship to be unfolded is one of physician-patient, in which the doctor is expected to do the best for the patient and always to act to maximize the patient's benefit, while reassuring the patient that privacy and confidentiality are protected. In forensic psychiatry the relationship is one of evaluation, where the foundation of neutrality demanded from the evaluator, and the fact that the evaluator is in no position to reassure the person on matters of confidentiality or privacy (18), could mean that negative findings will endanger the interests and cause harm to the person being evaluated, regardless of this person's health and the evaluator being a physician. Because of this, forensic psychiatrists may even be implicated in the criminalization of mentally ill persons (19).

To some commentators, the social control role of forensic psychiatrists sets them apart from the ethics of medicine and of psychiatry (20,21). These commentators waver on whether in their legal work forensic psychiatrists are operating as physicians – a point of view that has led to much controversy. From inception to appearance in court, the forensic psychiatrist derives the authority to act from the fact of being once and foremost a physician, hence having to uphold the ethics of medicine, but the end point effects of forensic evaluations are usually at the hand of other parties. This imposes on forensic psychiatrists an ethical obligation to scrutinize their motives and the motivations and possible final actions of those who hire them for evaluations, including ways on how data are obtained, how the evaluator arrives at opinions, how legal materials such as reports, memos, and expert evidence are prepared, and most importantly, what would be the final use of their findings.

A major controversy stemming from the double roles that forensic psychiatrists and other psychiatrists, such as those in the military, are called to fulfill relates to the use of psychiatric judicial hospitals in the Soviet Union and, more recently, in China, and psychiatrists' participation in interrogations of prisoners and detainees that could lead to allegations of torture, especially in the present climate of concern with terrorist activities (22). This includes turning over to interrogators confidential psychiatric material that could be used to pinpoint weaknesses and vulnerabilities of the prisoner (23), providing consultations on interrogation techniques or actively participating in deception techniques to gather intelligence (24). It is in this context that the end point motivations of those calling for evaluations cannot be lost on forensic psychiatrists or physicians in general. Participation on anything that could lead to torture will be a major trespass on the ethics of medicine. This also should be a clear reminder to forensic psychiatrists that medical ethical rules cannot be trespassed, no matter what the demands of the master (25).

CONCLUSIONS

We have identified four moments in the development of legal-psychiatric thinking. The first two moments – evolution in the understanding and appreciation of the relationship between mental illness and criminality, and consequent changes in the different tests of legal insanity – were applied to underline the increasing scope of forensic psychiatry in practically all areas of criminal law and in a large number of situations in civil law. The last two moments – new methodologies for the treatment of mental conditions that provide alternatives to custodial care, and changes of attitudes and perceptions of mental illness among the public – were applied to activities of forensic psychiatrists outside of courts of law. These activities range from the development and implementation of mental health legislation to how their knowledge of systems help mentally disordered offenders to navigate three inimical social systems and how they should be involved in the protection of human rights of mentally disordered offenders and the mentally ill in general.

On the matter of ethics, we have dealt with the controversies that the enlarged scope of action of forensic psychiatrists have created in the understanding of their social functions, from definitional problems to wavering about whose ethics they should abide by and on to the latest concerns about the use of clinical knowledge for purposes that should be completely out of their ethical boundaries.

Practitioners of forensic psychiatry have moved their specialty to a frontal role in society. They now have an obligation to make sure that they remain foremost physicians and that their ethics and motivations are beyond reproach and impeachment.

References

1. Gutheil TG. Forensic psychiatry as a specialty. Psychiatric Times 2004;21.
2. Pinals DA. Where two roads meet: restoration of competence to stand trial from a clinical perspective. Journal of Criminal and Civil Confinement 2005;31:81-108.
3. Konrad N. Prisons as new hospitals. Curr Opin Psychiatry 2002;15:582-7.
4. Weisstub DN. Inquiry on mental competency. Toronto: Queen's Printer for Ontario, 1990.
5. Nakatani Y. Psychiatry and the law in Japan. Int J Law Psychiatry 2000;23: 589-604.
6. Arboleda-Flórez J. On the evolution of mental health systems. Curr Opin Psychiatry 2004;17:377-80.
7. Morrisey JP, Goldman HH. The enduring asylum. Int J Law Psychiatry 1981;4:13-34.
8. DiScipio W, Sommer G. Therapeutic failures: patients who return within 30 days of hospital discharge. Psychiatr Q 1973; 132:1135-9.
9. Stuart H, Arboleda-Flórez J. Homeless shelter users in the post-deinstitutionalization era. Can J Psychiatry 2000;45:55-62.
10. Arboleda-Flórez J. Stigma and discrimination: an overview. World Psychiatry 2005; 4(Suppl. 1):8-10.
11. Hodgins S. Mental disorder, intellectual deficiency and crime: evidence from a birth cohort. Arch Gen Psychiatry 1992; 49:476-83.
12. Sheldon CT, Aubrey T, Arboleda-Flórez J et al. Social disadvantage and the law: predictions of legal involvement in consumers of community mental health programs in

Ontario. Int J Law Psychiatry (in press).
13. Arboleda-Flórez J. Integration initiatives for forensic psychiatry. World Psychiatry 2003;2:173-7.
14. Stuart H. Stigmatisation. Leçons tirées des programmes de reduction. Santé Mentale du Québec 2003;28:37-53.
15. Tannsjo T. Forensic psychiatry and human rights. http://www.priory.com/psych/rights.htm.
16. World Health Organization. Resource book on mental health, human rights and legislation. Geneva: World Health Organization, 2005.
17. Gutheil TG, Slater FE, Commons ML et al. Expert witness travel dilemmas: a pilot study of billing practices. Bull Am Acad Psychiatry Law 1998;26:21-6.
18. Gutheil TG. "The whole truth" versus "the admissible truth": an ethics dilemma for expert witnesses. J Am Acad Psychiatry Law 1998;31:422-7.
19. Boettcher B. Criminalization in forensic psychiatry. http://www.priory.com/psych/criminal/htm.
20. Appelbaum PS. The parable of the forensic psychiatrist: ethics and the problem of doing harm. Int J Law Psychiatry 1990;13:249-59.
21. Stone AA. The ethical boundaries of forensic psychiatry: a view from the ivory tower. Bull Am Acad Psychiatry Law 1984;12:209-19.
22. Moran M. AMA to Evaluate M.D. role in detainee interrogation. Psychiatric News 2005;40:6.
23. Lifton JR. Doctors and torture. N Engl J Med 2004;351:415-6.
24. Sharfstein S. Medical ethics and the detainees at Guantanamo Bay. Psychiatric News 2005;40:3.
25. Arboleda-Flórez J. Forensic psychiatry: two masters, one ethics. Die Psychiatrie 2005;2:153-7.