2 Forensic Psychiatry and the Mentally Disordered Offender: Ethical Issues in the Treatment Provision within Secure Hospital Environments—Clinical and Legal

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2.1 Generic Ethical Issues for All Psychiatry Disciplines

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2.1.1 What Are Ethics?

According to the Oxford Dictionaries, ethics is defined as the *moral principles that govern a person's behaviour or the conducting of an activity* (Oxford Dictionary 2017). Within medicine, ethics *usually operate within an established framework of values which serves as a reference from which to conduct the debate about the rightness or wrongness of an action* (Mason et al. 2003). In their book, *Principles of Biomedical Ethics*, Beauchamp and Childress (Beauchamp and Childress 2001) refer to four *moral principles*, namely, respect for autonomy, non-maleficence, beneficence and justice. *Principlism*, as this is known, has an important but imperfect role in considering medical ethics. Ethical concerns can be found throughout medicine, and with advances in medicine, these are likely to increase. Reproductive medicine and death are frequently debated subjects. More generally, there are

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questions around confidentiality and consent. In psychiatry coercion, restrictive practice and deprivation of liberty are particularly relevant, and within forensic psychiatry (albeit not exclusively), there is also the interface between health and the criminal justice system.

2.1.2 Recent History

In psychiatry, unlike other areas of medicine, patients can be treated against their will. According to the Mental Health Bulletin in the financial year 2015–2016, overall numbers detained under the Act had increased. *An estimated 1,805,905 people were in contact with adult mental health and learning disabilities services*, and of these an estimated 5.6% were admitted to hospital. There were 25,577 patients detained under the Mental Health Act 1983 on 31 March 2016; 20,151 were in hospital and 5246 were subject to Community Treatment Orders. In contrast, the numbers of patients detained under Part 3 of the Act have reduced to 1696 in 2015/2016 as compared to 2130 in 2011/2012. Whilst hospital orders have been imposed less frequently, there has been a marked increase of 25% in urgent transfers to hospital from prison under sections 48/49 in the last 3 years.

Back in 1957, the Percy Commission, which reviewed the law relating to mental illness and mental deficiency, concluded *the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty* (The Percy Commission 1957). In the aftermath of this, the Mental Health Act 1959 became legislation and introduced new safeguards. Patients were detained for their health and safety or to protect others from harm (Bluglass 1978). Clinicians rather than magistrates had the power to detain, and Mental Health Review Tribunals were introduced to review detention (Gooding 2014). Consent to treatment was covered, albeit was not specific, and it did not sanction treatment without consent for informal patients (Bluglass 1978). For those who had been detained, treatment could be given without consent. Although good practice suggested discussion with relatives, or obtaining a second opinion from a colleague, it is not clear when this was introduced and how extensively it was embraced (Hilton 2007).

Under the Mental Health Act 1983, consent to treatment was formalised with specific legal frameworks around treatment including psychosurgery, electroconvulsive therapy and psychotropic medication. Additional reforms included the introduction of the approved social worker (ASW) who was able to make applications for compulsory admissions. There were also duties on local authorities under section 117 to provide aftercare services to patients detained under specific sections after their discharge from hospital. The Mental Health Act Commission was also created. Its role was to protect the interests of detained patients, review the Mental Health Act, appoint doctors to provide second opinions with respect to consent to treatment, and devise a code of practice (Turner et al. 1999).

In the years following the introduction of the Mental Health Act 1983, a number of significant pieces of legislation were passed, including the Human Rights Act 1998 and the Mental Capacity Act 2005. Changes to mental health legislation had considered the implications of these Acts, particularly the Human Rights Act, and several articles of the European Convention on Human Rights have relevance to mental health law, most notably in relation to detention and compulsory treatment (Mason et al. 2003). Article 5, *everyone has the right to liberty and security of person*, is highlighted in the case of *Winterwerp v Netherlands* (1979) which stipulates that minimum criteria for detention under mental health legislation must be justified (Mason et al. 2003). Public authorities have a duty to adhere to the Convention, and a declaration of incompatibility has to be made if they cannot comply (Branton and Bookes 2010). Indeed, this happened in the case of *R (on the application of H) v. Mental Health Review Tribunal North and East London Region* (2001) such that the secretary of state introduced a remedial order reversing the burden of truth in a tribunal from the patient to the hospital (Branton and Bookes 2010).

Although the government had wanted to replace the Mental Health Act 1983, objections to many of its plans meant the 1983 Act was instead amended in 2007, with the changes coming into force in November 2008. The principle amendments include a simplification of the definition of mental disorder to *any disorder or disability of the mind* with the removal of the four subcategories. Exclusion criteria have also been modified such that *dependence on drugs or alcohol* remain but *promiscuity, or other immoral conduct, sexual deviancy* have been removed. Learning disability is an exclusion *unless… associated with abnormally aggressive or seriously irresponsible conduct*. Once detained for treatment, one of the criteria is *appropriate medical treatment is available*. The definition is wide and states: *nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care…the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations*. In effect, this allows those with personality disorder to be detained if the *purpose* is to alleviate the disorder. The amended Act also revised the professional roles. It introduced the Approved Mental Health Professional, which allowed other mental health professionals to take on this role (with the exception of doctors). Responsible Medical Officers were replaced with Responsible Clinicians, who could be non-psychiatrists, but initial detentions under the Act continue to require two medical doctors. This is controversial, particularly as according to Winterwerp, detention requires objective medical evidence, and under the amended Act there may be a non-medical Responsible Clinician. The introduction of Supervised Community Treatment through Community Treatment Orders replaced Supervised Discharge. This provides the power of recall followed by a 72 hour period in hospital for treatment, after which the Community Treatment Order can be revoked if a patient is not taking their treatment. As a result, leave of absence longer than 7 days requires consideration of Supervised Community Treatment.

The right to advocacy was also introduced. Independent Mental Health Advocates provided this service from April 2009 to help patients access information about

their detention, treatment and rights. (This is in keeping with Independent Mental Capacity Advocates available under the Mental Capacity Act).

Children's safeguards were added such that from April 2010 they had to be placed in *age-appropriate* settings with hospital managers having responsibility for this (Lawton-Smith 2008). The reality is there are 1459 CAMHS beds in England, of which 124 are low secure beds. Despite a 71% increase since 1999, according to the Education Policy Institute, the number remains insufficient and NHS England has agreed to provide 150–180 additional tier 4 beds (Campbell 2017).

The *Bournewood Gap*, in effect the detention of incapacitated patients under common law in the absence of safeguards or a right to appeal, was addressed by using the Act to amend the Mental Capacity Act of 2005 and introduce Deprivation of Liberty Safeguards. It was also used to amend the Domestic Violence, Crime and Victims Act of 2004 such that victims of violent or sexual offences detained in the hospital were allowed to make representation around conditional discharge and conditions if discharged under a Community Treatment Order (Lawton-Smith 2008).

2.1.3 Generic Ethical Issues

It is positive, as described above, that safeguards related to detained patients have increased over time. Nevertheless, both detained patients in hospital and those subject to a Community Treatment Order, or a conditional discharge from a hospital order with restrictions, may feel coerced into taking treatment. Capacity to consent to treatment is assessed, and if required, a second opinion appointed doctor provides a view. However, if a patient has capacity to consent and decides to refuse, and if the second opinion doctor concurs with the opinion of the treating team, they have no choice but to take the treatment (or be recalled, if in the community and they continue to refuse). Capacity to consent to treatment is not the only area in which a patient may find they lack control, even if they are capacitous. Patients do have recourse to appeal using the Mental Health Tribunal, and the burden now rests with the hospital to justify the detention/order. And whilst those providing evidence to the Mental Health Tribunal, particularly oral but also written, must justify detention, it may be difficult to do so in a manner that is not harmful to the therapeutic relationship. For those who have general welfare needs (not just medication requirements), guardianship allows care in the community where it cannot be provided without compulsory powers.

Detained patients are likely to have access to medical records through Mental Health Tribunal reports, and Care Programme Approach reports may also contain detailed information. Patients in hospital are often able to apply to see their records directly, and their legal representatives frequently make requests to view the records. Patients can request access to their medical records through a Subject Access Request (SAR), which is set out in the Data Protection Act of 1998. There are rules around this including the period by which the request should be met (How do I access my medical records (health records)? http://www.nhs.uk/chq/pages/1309.aspx?categoryid=68).

Confidentiality is noted by the General Medical Council as an *important ethical and legal duty but it is not absolute.* It discusses reasons when *one may disclose personal information without breaching duties of confidentiality*. Justification includes the patient consenting, disclosure to the benefit of the patient when they are unable to consent, disclosure required by law or as part of a statutory process, and disclosure in the public interest. Ideally, consent to disclose information should be requested. If the patient lacks capacity, information should be discussed with someone appointed to make health and welfare decisions for them. Information should be disclosed if the patient is at risk of serious harm and it is required by law. Even if it is not required by law, if there are concerns about risk to the patient, it should be disclosed, unless it will not benefit the patient. In capacitous adults, if the patient refuses, this should generally be accepted, even if they put themselves at risk of serious harm. This does not necessarily apply if someone else is at risk as well. Disclosure in the public interest without consent may not be straightforward and should be discussed with the Caldicott Guardian or other expert if possible (GMC 2017). The British Medical Association provides similar guidance. Their guidance notes: *in the absence of evidence to the contrary, patients are normally considered to have given implied consent for the use of their information by health professionals for the purpose of the care they receive. Information sharing in this context is acceptable to the extent that health professionals share what is necessary and relevant for patient care on a 'need to know' basis. Health and social care, although often closely related, do not always fall into the same category, and disclosure of information to social services usually requires explicit consent from competent patients.* (BMA 2016). The case of *W v Egdell* (1990)[1] sanctioned the duty to disclose private information if there was a risk to the public. Although ideally consent should be sought, prevention of harm can justify a breach (Adshead 2014). Indeed, the case of *Tarasoff* in the USA went further and highlighted the *duty to protect, not a duty to warn* (Felthous 2006).

In considering research, given forensic populations are often compulsorily detained, informed consent is important, as well as the ability to veto research that could lead to a direct risk. In epidemiological and clinical research, anonymisation and secure coding are often used in an effort to reduce the risk of breaches of confidentiality (Munthe et al. 2010).

2.1.4 Conclusion

Ethical concerns can be found throughout medicine, and with advances in medicine, these are likely to increase. The principles of respect for autonomy, non-maleficence,

[1] W had schizophrenia and was detained in a secure hospital having shot seven people, killing five. Dr. Egdell was asked to prepare a report for a tribunal by his solicitor, but the application was withdrawn as the report noted an interest in guns and homemade bombs which predated his illness. Dr. Egdell sent a copy to the hospital and asked the hospital to send it to the tribunal. W claimed he had breached his confidentiality, but the court found in Dr. Egdell's favour due to the grave risk of harm.

beneficence and justice are key within all medical disciplines, as are questions around confidentiality and consent. In psychiatry, the safeguards related to detained patients have improved, but issues around coercion, restrictive practice and deprivation of liberty are considerations in everyday psychiatric practice. Forensic psychiatry also faces additional challenges arising from the interface between health and the criminal justice system.

In the following section, the focus will be specific ethical issues in the treatment provision within forensic psychiatry, especially within secure hospital environments. Particular emphasis will be placed on how the relationship between professionals and the patient is different in forensic psychiatry compared to other psychiatry settings and will discuss pertinent ethical considerations.

2.2 Specific Ethical Issues Related to Forensic Psychiatry

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Many of the ethical issues found within psychiatry may be heightened within forensic psychiatry, as by definition the patients are detained or subject to some sort of compulsory measures. Patients may have been admitted through the courts directly and transferred from prisons or other non-forensic hospitals. The involvement of forensic psychiatry services usually has a dual function: on the one hand, the assessment and treatment of a patient that presents with a mental disorder, and on the other hand, addressing the association of such mental disorder with offending; therefore, part of its role may also be to protect the public from future harm. As such, patients may be in the hospital for prolonged periods with complex relationships with their Responsible Clinician and other members of the team.

In addition to generic issues around detention, consent versus coercion and confidentiality managing forensic psychiatry patients bring into consideration issues stemming from the interface between psychiatry and the legal system as well as environmental factors such as hospital security, exclusion zones, restrictions or treatment in prisons/detention centres. Additional issues that need consideration include the effects of long periods of detention and case management from the Ministry of Justice, report writing and the effect on therapeutic relationships (court, annual progress and tribunal reports), scarcity of community placements that can manage both mental illness and criminality or risk of recidivism, imposition of therapies to progress, long-term segregation/seclusion, and high-dose medications to manage behaviours.

2.2.1 Deprivation of Liberty

The use of the Mental Health Act 1983 to detain patients considered to be mentally ill continues to rise. In the UK during 2015/2016, the total number of detentions under the Act was increased by 9% to 63,622 compared to 58,399 detentions in

2014/2015. This compares with an increase of 10% between 2013/2014 and 2014/2015 and is the highest number since 2005/2006 (43,361 detentions) (Annual Statistics 2016). The use of section 136 of the Mental Health Act 1983 (under which people can be brought to the hospital as a 'place of safety' where they are assessed for the presence of a mental illness/disorder) has also increased by 18% to 22,965.

Deprivation of liberty or liberty restrictions for patients detained in psychiatric hospitals are a common concern for psychiatric systems worldwide. Kuosmanen et al. in their 2001 study investigated whether patients had experienced deprivation of their liberty during psychiatric hospitalisation and sought their views about it. Their participants reported that the main restrictions of their liberty whilst in a psychiatric hospital included restrictions regarding leaving the ward, restrictions on communications, confiscation of property and the use of various coercive measures. The patients' experiences of being deprived of their liberty were unanimously negative, although some saw the rationale for using these interventions, considering them as part of hospital care (Kuosmanen et al. 2007).

Deprivation of patients' liberty may arguably be justifiable in occasions where priority is maintaining their safety (and the safety of others, including patients and staff) and preventing further deterioration of their mental state. A variety of methods are used in psychiatric hospitals to maintain safety including restrictions of patients' freedom to discharge self and leave the hospital, detention under the Mental Health Act, and restrictions of leaving the ward temporarily as a voluntary patient could do. Other methods, such as the use of seclusion or the use of restraint and forced administration of medication, are more controversial and generate a number of moral concerns. Deleterious effects and negative experiences of seclusion and restraint have been reported by patients who perceive them as punitive, coercive and traumatic. In spite of controversial research results and international recommendations, seclusion and restraint are part of everyday psychiatric hospital care, although empirical evidence of the effectiveness of these methods is still lacking. Several alternative approaches could be used to minimise the use of seclusion, restraint and forced use of psychotropic medication including timely de-escalation, empowering the patient to participate in decisions involving their care and the use of advance directives.

Mental health legislation is put in place to ensure not only that a patient is treated in the least restrictive environment with the least restrictive approach but also an acceptable quality of interventions involving deprivation of patients' liberty in psychiatric hospital care. Despite such legislation being advanced in some countries such as the UK, there is great variability of both legislation quality and content (e.g. the process of involuntary admission and treatment, and relevant safeguards), between European Union member states and worldwide. In some countries, relevant laws and regulations are outdated, and on occasion they serve to deprive patients of their rights rather than protect them.

Ethical considerations involving deprivation of liberty are more pertinent in some forensic psychiatric settings such as medium- and high-security forensic psychiatric hospitals where all patients are detained under the Mental Health Act.

2.2.2 Confidentiality

Trust is an essential part of the doctor-patient relationship, and confidentiality is central to this. Patients may avoid seeking medical help or may underreport symptoms, if they think their personal information will be disclosed by doctors without their consent or without the chance to have some control over the timing or amount of information shared.

The issue of confidentiality regarding patient information and disclosures has always been one of the most thought-provoking issues within the medical practice universally and even more so when it involves an area of clinical practice where medicine and law interfere, such as is forensic psychiatry. As discussed earlier in the chapter, confidentiality is an *important ethical and legal duty but it is not absolute* (GMC 2017).

Due to its great importance in patient care, the General Medical Council in the UK provides an exclusive guidance on what confidentiality involves and the duty of doctors to preserve it (by managing and protecting patient information) and also outlines the framework for considering when it is appropriate to disclose patients' personal information (GMC 2017). This guidance covers rules regarding:

(a) Disclosure to support the direct care of an individual patient
(b) Disclosures for the protection of patients and others
(c) Disclosures for all other purposes

As a general rule, the GMC guidance highlights that good practice in handling patient information means seeking the patient's consent prior to disclosing his or her specific personal information. It is however occasionally the case in psychiatry, and particularly in forensic psychiatry, that the psychiatrist might need to disclose information about the patient without the patient's consent:

1. Disclosures approved under a legal process

   The forensic psychiatrist can disclose personal information without consent if the disclosure is permitted or has been approved under section 251 of the National Health Service Act of 2006 which applies in England and Wales or the Health and Social Care Act of 2016 (Control of Data Processing) in Northern Ireland. These pieces of legislation allow the common law duty of confidentiality to be set aside for defined purposes where it is not possible to use anonymised information and where seeking consent is not practicable. There is no comparable legal framework in Scotland.
2. Disclosures in the public interest

   Confidential medical care is recognised as an important right for every person and is believed to serve not only the specific person's best interest but also the public interest. This is based on the fact that if people are encouraged to seek advice and treatment for their medical symptoms and conditions, they are benefited, but also society is benefited directly or indirectly. On occasion though,

there can be a public interest in disclosing patient information, and the medical practice allows it if the benefits to an individual or society outweigh both the public and the patient's interest in keeping the information confidential. For example, disclosure may be justified to protect individuals or society from risks of serious harm, such as from serious communicable diseases or serious crime.

3. Disclosures about patients who lack capacity to consent

   Forensic psychiatrists, as all clinicians within their own practice, must work on the presumption that every adult patient has the capacity to make decisions about the disclosure of their personal information. They must not assume a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), beliefs and apparent inability to communicate or because they make a decision they disagree with. They must assess a patient's capacity to make a particular decision at the time it needs to be made, recognising that fluctuations in a patient's condition may affect their ability to understand, retain, weigh up information or communicate their decision. They should also allow time if possible for the patient's capacity to restore (if their condition allows it) before disclosing information. In case of lack of capacity to consent to disclosure of personal information, the psychiatrist has the obligation to disclose only proportionate and relevant information.

In forensic psychiatry, it is quite often the case that patient's personal information (including medical, psychiatric and social history, other conditions and behaviours as well as progress) are disclosed in an obligatory fashion to courts, tribunals and regulatory bodies (BMA 2017). The courts, including the coroner's courts, magistrates and crown courts, Mental Health Tribunals, and bodies appointed to hold inquiries such as the General Medical Council, have legal powers to require disclosure, without the patient's consent, of information that may be relevant to matters within their jurisdiction. Applications for court orders must be served on patients who, if they object to the disclosure of the information, must be given an opportunity to make representations to the court. In cases that these applications are served on the healthcare organisations where the patient resides, when they should be served on patients, it is the obligation of the healthcare provider to inform the patient of the application, so they can make their representations to court as necessary. Where a court order is served to the treating forensic psychiatrist (and involved health professionals in general) to provide evidence about a particular patient, then they are justified in disclosing information when they believe that this is a reasonable request, and they should disclose only as much information as is requested or they believe is required. Failure to comply with a court order to release records may be an offence, but health professionals should object to the judge or presiding officer if they believe that the records contain information that should not be disclosed, for example, because it relates to third parties unconnected with the proceedings. In any case, patients should be informed of disclosures ordered by a court.

These circumstances extend to report writing, when a psychiatrist or forensic psychiatrist is called as an expert witness (McClure 1999). Report writing comes however with additional ethical concerns.

Peter Gaughwin, in his article, makes a strong case that, notwithstanding the nature of the adversarial system, *the obligations to the legal system* (of medical practitioners providing medicolegal reports) *are those to the court, not necessarily to the referring lawyer*. He also highlights that treating psychiatrists, in particular, are subjected to considerable pressure, mostly arising from the patient's transference, to *please the patient* and provide that which is sought (i.e. a favourable report) (Gaughwin 1998).

Similarly, Paul Appelbaum (1997a, b) reflects on arising ethical issues such as *how ought a treating psychiatrist respond when a patient or the patient's lawyer requests that the psychiatrist prepares a report on the patient's unsuitability for custody of a child or agree to testify on the degree of emotional harm the patient suffered in an automobile accident*? Optimally, patients should be told why such behaviour threatens to undermine ongoing treatment. Applebaum suggests that an offer should be made to help identify another clinician to perform the forensic evaluation and argues how this response can have a powerful, positive effect on the psychiatrist-patient relationship (Appelbaum 1997a, b). From this, it would seem reasonable indeed that the only ethically available course of action for a treating psychiatrist is to decline any involvement in his or her patients' legal problems, whether civil or criminal.

It is however the case in some jurisdictions that clinicians (most often psychiatrist) do not have an option and are expected to acquire a dual role. Such is the case in some US states, particularly in smaller systems where there may be a limited number of providers, where psychiatrists working in correctional services may find themselves simultaneously assuming a treatment role and the role of a forensic evaluator (Cervantes and Hanson 2013). These two roles can at times be in conflict, as psychiatrists who assume the care of an inmate for purposes of treatment, are expected to act in the inmate's best interests, whereas forensic evaluators serve the interests of the judicial system. Such expectation of a dual role occurs despite a well-established and widely accepted principle that acting in dual roles (as a forensic evaluator and a treatment provider) for the same individual is not advisable and can lead to ethical conflicts (Strasburger et al. 1997; Reid 2002; Appelbaum 1997a, b; Sen et al. 2007; Konrad 2010).

Although there may be some advantages to having an evaluator assume both roles for the same individual from an efficiency standpoint, there are significant problems, including difficulty remaining objective and potential damage to the treatment relationship.

Nevertheless, whilst forensic psychiatrists may have the option in some jurisdictions to refuse writing medicolegal reports and present as expert witnesses for a civil or criminal law case that their patients are involved with, they have no choice in writing reports for Mental Health Tribunals, Annual Reports for the Ministry of Justice and other official reviews. Inevitably, this can cause strain in their therapeutic relationship with the patient and highlights the specific demands in the role of a forensic psychiatrist.

2.2.3 Ethical Dilemmas Arising from the Unique Relationship Between Patient and Clinicians in Forensic Psychiatry Settings

Naturally, the question arises of how we can balance good patient care, good therapeutic relationships and at the same time treatment imposing and freedom restrictions in secure settings.

Patient-focused research has indicated that most experiences of patients can be traced back to one core experience that makes the difference: *Am I being listened to?* (van den Hooff and Goossensen 2014). If patients experience being genuinely listened to, they feel more respected as human beings and less emotionally abandoned. The challenge for professionals is to explicitly pay attention and listen empathically to patients' struggles, whilst at the same time make the decision to treat the patient in a psychiatric hospital not voluntarily but detained using the Mental Health Act.

Fisher (1995), in his research focusing on the experience of nursing staff working in secure settings, concluded that balancing support for patient autonomy with the need to maintain unit control, was experienced by nurses as a tension between their desire to give patients latitude to manage their own behaviours, and their simultaneous responsibility for maintaining unit safety. As one nurse described it, this balancing is the very essence of psychiatric nursing practice: *...my whole job is to balance how much control to allow the patient and how much control to assume*. In the example that follows, a subject anguishes over the decision to give a patient the opportunity to manage his own behaviour: *I thought we were beginning to develop a good trusting relationship, but this particular day I got a funny feeling from what he was saying. He managed to contain his anger, but then walked into the dining room and hit another patient. He drew blood. I felt like I should have been able to see that coming. I wanted to give him a chance because he had handled himself before*. Another nurse stated, *I'm always asking myself, 'Did I act punitively?' 'Did his [the patient's] actions warrant my reaction?' or 'Did I act too quickly?'* These data characterise the actual mental struggle of the forensic psychiatric nurses as they attempt to find balance in their practice. Learning to balance support for patient autonomy with the need to maintain unit control evolves with experience in practice (Fisher 1995).

Such burning questions and concerns are as much relevant to nursing staff as to all mental health practitioners involved in the treatment provision within secure hospital environments, and forensic psychiatrists are not an exception.

Focusing on forensic psychiatrists, their practice has to be led by the universal psychiatric ethical rules: a psychiatrist must be able to demonstrate responsible patient care and ethical behaviour, with an emphasis on integrity, honesty, compassion, confidentiality, informed assent or consent, professional conduct and conflict of interest (American Board of Psychiatry and Neurology 2012). These rules not only ensure good patient care but also are an important step of building honest therapeutic relationships with their patients. At the same time, however, the legal system is counting on psychiatrists to answer questions such as the individual

patient's competency to stand trial, their intent to commit a crime, and the recommendations for treatment, management and supervision (Simon 2003). Whilst forensic psychiatrists often get the balance of safeguarding their therapeutic relationship with their patients and satisfying the legal system right, the effort behind keeping that balance is at times overwhelming.

In some countries, the legal system can become so entwined with the forensic psychiatry system that not only the therapeutic relationship of doctor-patient suffers but also questions are asked of forensic psychiatrists that are beyond their competencies. It is evident that, increasingly, voices within the global forensic psychiatric community are reiterating that the role of forensic psychiatry is to provide knowledge into the criminal psychopathology, within its limitation, but not to provide opinion regarding moral concepts such as evil.

The causes, development and management of criminal behaviours are legitimate areas for forensic study. When such criminal behaviours are associated with mental health problems, then forensic psychiatry has a role to play in the assessment, diagnosis and treatment of mental disorders so that indirectly criminal behaviours are reduced or diminished. The Gordian knot of evil however cannot be untied by forensic psychiatry. It is unreasonable to expect forensic psychiatrists to provide credible testimony about evil. Forensic mental health professionals have an important, but limited, consulting role when advising the courts about psychological matters including mental health. It is the law's final moral judgment of guilt upon individuals whom society brands as evildoers. This is more fundamental in some US states when evaluating the role of the psychiatrist in capital proceedings, and punishment and interrogation of detainees. It seems antithetical to the medical role the participation in criminal proceedings where psychiatrists are expected to assess fitness to be executed. Subsequently, a number of ethical and professional dilemmas arise: what should happen if incompetence is found, who would work to restore competence, does it need to be restored, and when a psychiatrist gives evidence to assist a judge to determine competence, is it deemed different from participation in capital punishment?

2.2.4 Forensic Research

When it comes to conducting research involving mentally disordered offenders, the ethical issues are as complex as those in everyday practise in forensic psychiatry. The forensic psychiatry population is indeed a very vulnerable patient population.

As very eloquently described in a recent article published in Bioethics: *The most serious threat to the ethical defensibility of forensic psychiatric research on selectively detained MDOs, is not the actual research situation and direct interaction between researchers and subjects. Instead, it resides in that step of the research process when the results are communicated to the wider society. Much of current practice in connection with forensic psychiatric risk assessment and media and policy consultancy is highly questionable for the simple reason that it serves to uphold and strengthen a prejudicial picture of MDOs, and people with mental health problems in general, that harms these people and supports unjust legal*

practices. In effect, we have argued that strong statements from scientific and professional organizations in support of a scientifically well-founded revision of forensic psychiatric risk assessment and consultancy practices are urgently called for (Munthe et al. 2010).

It is thus evident that ethical issues such as informed consent in the forensic psychiatric context, and questions such as when and how to communicate results derived from forensic research, can be daunting and difficult to answer.

2.2.5 Conclusions

Although the subject and the complexity of specialty requirements in the forensic psychiatric context (mental health diagnosis and management, law in mental health, boundaries, medications, psychological therapies, risk assessment and management, importance of the use of clinical judgement and evidence-based tools, skills in working in high pressure, different environments, long periods spent looking after patients [tolerance from both sides]) is seemingly endless, and the ethical issues that arise generate more questions than actually provide answers, it is vital to the forensic psychiatric community to actively voice these questions. It is important for forensic psychiatrists to keep revisiting these questions and challenge medical practice to maintain high ethical standards as they balance a very sensitive and demanding field, that between psychiatry and the law.

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