10 The Roles of Forensic Psychiatrists and Psychologists: Professional Experts, Service Providers, Therapists, or All Things for All People?

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10.1 Forensic Mental Health Professionals in Europe

The practice of forensic psychiatry varies between European countries, but our core values and recognition of its various possible roles have much in common. Where there is speciality recognition in the field of forensic mental health, other clinical professionals generally subscribe to a similar position. For forensic psychiatrists, the common ground is sufficiently great that the Ghent Group, an informal group of forensic psychiatrists from all European Union countries, readily agreed on a definition of forensic psychiatry (http://www.ghentgroup.eu/). This had to support the various roles in the speciality and acknowledge its medical roots and ethic. The extensive knowledge base required includes, but is not confined to, psychological medicine in all its aspects, relevant law, criminal and civil justice systems, mental health systems, and the relationships between mental disorder, antisocial behavior, and offending. The highly specialist skills required to encompass risk assessment and management, the giving of evidence in court and the management of care and treatment in secure settings. We recognize the developmental roots of offending and disorder (singly and in combination) in histories of victim experiences and failures of attachment and the relevance of these to the prevention of further victimization. The Ghent group definition of forensic psychiatry is:

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– A specialty of medicine based on a detailed knowledge of relevant legal issues, criminal and civil justice systems, and the relationship between mental disorder, antisocial behavior, and offending. Its purpose is the care and treatment of mentally disordered offenders, and others requiring similar services, including risk assessment and management and the prevention of further victimization.

Once it is acknowledged that care and treatment of offenders with mental disorder are at the heart of our work, then it is also apparent that in almost every role, there are tensions to be recognized and resolved if all relevant roles are to be taken up effectively and ethically. This is not unusual in medicine, since in any specialty, there are occasions when the well-being and wishes of the patient, generally the guiding principle for any doctor, cannot be the only consideration. Anyone with a highly infectious or contagious condition, for example, will require the best possible care and treatment for that condition but, on occasion, may have to be treated in isolation from others, whether s/he wishes to be or not, because of the seriousness of the condition should it spread to others. Perhaps the most often tension considered for forensic mental health clinicians is the interface between having a person in treatment as a patient and being requested to provide expert evidence to a court on some aspect of that individual's suffering or behavior. If an individual is taken into forensic mental health services, however, someone has to take legal responsibility for that individual's care and control and confinement—"the responsible clinician"—which means that s/he will be closely involved in defending continuing detention or petitioning discharge. To what extent can such a "custodian" also be a therapist? Then, by definition, forensic mental health professionals not only work within a multidisciplinary clinical team, where ethics and standards of behavior can generally be agreed with relative ease, but most also have an interagency role which works with the courts but extends far more widely too. This role relates most closely to public safety and membership of such groups and processes, such as the Multi-Agency Public Protection Arrangements (MAPPA) in England and Wales, as described and regularly updated by the Ministry of Justice (www.mappa.justice.gov.uk), with professional guidance provided by the Royal College of Psychiatrists [1] or the Round Table in Germany [2]. Under such conditions, clinicians find themselves required to share usually protected clinical information, albeit the minimum necessary, with the police, housing bodies, and other community agencies with entirely different but no less valid concerns and ethical models than clinicians. Another aspect of promoting clinical safety is enshrined in duties to victims of the actions of offender-patients. In the UK, for example, roles in this respect are embedded in law—The Domestic Violence, Crime and Victims Act 2004. In the criminal justice system, victims and offender issues are explicitly covered by different people, but there is a disproportionately high likelihood that patients in forensic mental health services have attacked someone within their family, or close social circle [3] means that these roles can rarely be so neatly circumscribed, bringing an extra tension to them. Duties to inform the victim about review hearings and support them in giving evidence to these if they wish, generally fall to dedicated staff within the probation service, but the patient's responsible clinician must be satisfied that this

has taken place and cooperate with the necessary process. The victim may be allowed to specify conditions of release, such as limits to where the offender patient may live or travel, and the clinical team must abide by these too. In still further roles—and the tensions inherent in them—we have more in common than not with other clinical specialties, but still they have to be acknowledged and kept under review. Teaching and training, research, service development and management, standard setting and monitoring, and public advocacy for our service users and their services are all tasks at the core of good practice. While many of the tensions in these roles will be around time management—the balance between time given to reviews and time allocated to actual clinical care—we also have to be able to deal with such matters as confidentiality when outside agencies need good enough information to complete an adequate inspection. When people are in desperate need of services but in our considered judgment those services cannot be delivered effectively, when should we make this a matter of public debate? When should we walk away from trying to deliver a service that we have grounds for judging inadequate? These last are not idle questions for an exercise in debate. In England and Wales, for example, where a number of prison officers have been cut in the face of a continuing rise in the prison population and well-documented contemporaneous rise in suicide, self-harm and assaults, at least one forensic psychiatrist makes the decision to walk away from a service that she thought could not be delivered adequately rather than risk colluding in any pretext that the existing situation can be supported. Even the highest quality mental health services in prisons are dependent on adequate general prison staffing for ensuring appropriate and timely access to prisoners.

10.2 Psychologist Roles

Haward [4, 5] detailed the expert roles of psychologists as: "clinical," "actuarial," "advisory," and "experimental." For psychologists, even the most frequently requested role—the clinical—relies much more on formal testing than it would for psychiatrists. The psychologist would generally use tests with established reliability and validity of, for example, IQ, personality characteristics, or neuropsychological functioning, although, in some part, the training of clinical psychologists is now viewed as preparing them for the task of diagnosis [6].

Actuarial roles involve offering statistical probabilities of an event. While a plethora of risk assessment tools have been developed, investigated and reported in the literature, in the field of mental health, it is exceptionally difficult to use even these in real-life situations. Systematic reviews of research evaluation of these tools show the apparent limits to their predictive power in practice (e.g., [7]). Although hard to prove, this is more than likely due to the fact that when used in clinical practice, they are coupled with risk management. Perhaps in this context, we should be disappointed that these tools do not apparently seriously overpredict dangerous behaviors, but the low base rate of serious offending is another relevant explanation here. The great advantage of these tools is that they can produce improvements in transparency of how risk determinations are made, although a

potential problem is that any attempt to present information numerically—as risk scores—can give rise to implications about their scientific strength which are not justified. In other circumstances, in the UK, a pediatrician's use of probability estimates of the chances of "cot death" explaining the deaths of two babies was a major factor in their mother being convicted of killing them. The impressive sounding estimates were, however, wrong and led not only to a miscarriage of justice in this case but also in a series of similar cases. The Royal Statistical Society considered the matter and issued guidance on communicating expert statistical evidence in court [8].

The evaluation of competency provides an illustration of the evolution of forensic psychology and of how the advisory role has developed. Determination of competency is a court decision based on clinical opinion, and never, in law, a clinical decision. Nicholson and Kugler [9] conducted a review of comparative research on defendants tested for competency to stand trial before the criminal courts. They found 30 studies encompassing 8170 people between them. In terms of effect sizes, the strongest characteristics related to incompetency were (a) poor performance on psychological tests or interviews specifically designed to assess legally relevant functional abilities, (b) a diagnosis of psychosis, and (c) psychiatric symptoms reflecting severe psychopathology. To a lesser degree, traditional psychological tests, previous psychiatric hospitalization, previous legal involvement, marital resources, and demographic characteristics were also related to competency status. Thus, bringing together a mix of loosely structured and more rigidly structured assessments may be optimal.

Perhaps one of the most exciting areas in which psychologists have contributed to court work is that of relevant "experiment." Gudjonsson has taken a leading role in this field. While perhaps best known for his development of tests of suggestibility, which, in the UK have been so crucial in avoiding or helping to overturn miscarriages of justice (e.g., [10]), he has also shown how tailoring tests to the needs of individual cases can shed light on limits to competence or on relevant but highly specific deficits. An example of the former was to elucidate the extent of abilities of a young woman with intellectual disability to give accurate evidence to the court about her assailant; the defendant's lawyers introduced arguments that she was wholly incompetent, but tests devised for the specific circumstance showed that in crucial areas of, for example, visual identification, she could be accurate and have accurate recall [11]. In another case, a man had inexplicably attacked his wife; through detailed neuropsychological testing, he was able to offer an explanation which was accepted by the court [12].

In the domain of civil law, there is an increasing demand for clinical neuropsychologists to assess and testify on disability and individual injury in compensation cases. In the domain of domestic and family law, clinical forensic psychologists play is also expected to play a substantial role [13]. Furthermore, many jurisdictions allow expert testimony on whether a child has been the victim of sexual abuse, an area where Gudjonsson's work on suggestibility is also highly pertinent. Heltzel [13] outlined the extent of the legal system's "voracious appetite for information." Ireland's [14] work, which evaluated the quality of reports to the family court, provides

evidence of the importance of both qualifications as an expert and maintaining relevant experience if the quality of reports is to be sustained. She happens to be a university professor of psychology, so focused on psychology reports. Given the very personal hostilities toward her that this important work precipitated, it is perhaps unlikely to be repeated with psychiatrists, so psychiatrists must take these lessons from psychology for their own work.

10.3 Treating Clinician or Expert Witness?

While forensic psychiatrists may be called to give evidence in court as witnesses of fact, in which case, their duties are the same as for any other citizen, they are generally called as expert witnesses. An expert witness is defined by training and/or experience, with a requirement to assist the court in matters outside the knowledge or experience of the court. There are the same expectations of an expert in respect of relevant matters of fact relevant to their argument—to report truthfully and accurately—but the important difference between witnesses merely of fact and expert witnesses is that the expert is not only allowed to express opinions but expected to do so. An obvious concern that follows from this is that opinion is susceptible to conscious and unconscious biases and that a professional clinician who is treating the person for whom she/he is providing the report may have a quality of relationship with that person that renders bias inevitable. The next common assumption is that the bias will necessarily favor the individual; this is not necessarily the case. Any lengthy relationship between clinician and patient may lead to negative countertransferences as well as positive regard. Some authors, such as Strasburger et al. [15], have argued that the processes of psychotherapy and expert forensic mental health evaluation for the courts are fundamentally incompatible, and create an irreconcilable role conflict such that combining the tasks should be avoided whenever possible. Others (e.g., [13]) have argued to the contrary that there is no justifiable reason why a competent psychologist (or psychiatrist) cannot and should not conduct an objective and appropriate evaluation of a patient seeking clinical services as a basis for the treatment. In common law countries, the concern may be less about whether the expert is also treating the defendant or plaintiff and more about who has commissioned the report. The General Medical Council (GMC)—the UK's professional body for all doctors—warns:

"*You have a duty to act independently and must not be influenced by the party who retains you*" (GMC 2008) [16].

In the UK, a distinction is sometimes made between an expert witness and a professional witness, the latter, by definition having had professional clinical involvement with one or more of the parties involved in the case. Full transparency about the level of training and/or experience that qualifies the expert witness to take that role and about the nature and extent of any relationships pertinent to the case is seen as the most crucial issue. An important problem is that there are few empirical data on which to offer any guidance in this area.

Ghent group members came together to debate the issue, and this work was reported and supplemented by a systematic literature review and a survey of forensic psychiatric representatives from each EU jurisdiction [17]. Almost all published literature proved to be polemical and, thus, itself biased. The one directly relevant empirical paper showed good agreement on diagnosis between treating clinicians and independent experts, except in the case of the rarely diagnosed (in this context) anxiety disorders or the attribution of psychosis to substance misuse (kappa 0.3—significant but weak) [18]. The European expert survey highlighted differences in practice between countries, so the conclusion was:

On current evidence, either separation or combination of clinical and expert roles in a particular case may be acceptable insofar as there are national legal or professional guidelines on this issue, anyone practicing in that country must follow them and may safely do so, regardless of practice in their native country. The most important ethical issue lies in clarity for all parties on the nature and extent of roles in the case ([17], p. 271).

10.3.1 Some Notes on the Belgian Legal System

The Belgian legal system is inquisitorial. For further description of the inquisitorial system (and the adversarial system), see the chapter on Adversarial versus inquisitorial legal systems. This section will address the issue when a judge examining the case relies on a single expert clinical witness for guidance on the likely role of mental disorder in the offense and on clinical needs. There is no official list of experts in Belgium nor nationally accepted guidance on the style and content of expert reports. A project to devise and implement a mandatory form for them is, however, underway jointly between the Ministries of Justice and Health. The principle of separation between clinician and expert is at one end of a continuum, with "expert evaluation" and "treating" clinical teams in prison. The psychiatrist, surrounded by several psychologists, working in evaluation teams, is asked to assess personality, cognitive, and risk characteristics. All prison psychologists have a clinical background. Some have a specific forensic psychology background organized by several universities only, not all of them. Once engaged by prison authorities, all psychologists follow further specific training (e.g., dynamic risk assessment evaluations) co-organized by prison authorities. In the beginning of the 1980s, there were hardly any psychologists in Belgian prisons; today, there are 166 for a prison population of around 10,600. Since 2014, the average number of new receptions into prison annually has been just in excess of 400. The main tasks of these psychologists are to inform courts about individuals appearing before them, thus assisting the court to make sentencing decisions and, later, to provide reports for the prison authorities to help make release decisions. These clinicians also oversee interventions and rehabilitation programs for offenders while they remain in prison and have a so-called pre-therapeutic role. These psychologists prepare offenders for psychotherapy or rehabilitation and supervision in the community. However, there is no specific structure treatment nor transition programs in Belgian prisons.

Belgium differs from many European countries in that most people found not guilty by reason of insanity—called "internees"—are held in prison while they are supposed to be treated in secure hospitals.

Since 1930, Belgian government approved a law called "social defense" in order to "protect society against criminal behavior." Since then, "internees" who are severe mentally disturbed people, who have committed criminal acts, never get punished for their criminal acts but are criminally insane and in need of psychiatric care to prevent them from committing any further crimes. This law has long been the landmark to organize forensic psychiatric care in Belgium. However, after a number of cases heard before the European Court of Human Rights [19, 20], two new secure hospitals opened recently. For those prisons in Belgium which have a designated psychiatric unit, traditional multidisciplinary clinical teams treat offenders, most of whom committed their offenses while mentally ill and are internees. These professionals are involved in therapy and rehabilitation efforts and no social or clinical information passes between evaluation and therapy teams. This situation, designed to abolish the dual role conflict, has created some frustration between "evaluation" and "treatment" professionals and prisoner-patients alike. Indeed, "treatment" clinicians complain that assessments have to be repeated needlessly, while "evaluation" professionals complain about inability to access information on progress which would be relevant to release decisions. Inside the forensic "social defense" system, there is no strict separation between evaluation and therapy. From the beginning and until their definitive release, every 6 months, such people are examined before a court which considers evidence of mental state change and readiness for release into society. Although some [21] recommend a strict separation between the evaluation and treatment teams here too, the system rather supports the bringing together of evaluation and therapy efforts to maximize benefits for offenders and public alike.

Conclusions

When assessing or treating offenders who have mental disorders, lead clinicians often find themselves combining clinical and legal roles. Concerns about doing so seem to crystallize out most prominently in respect of giving evidence in court or to legal bodies—so much so that some countries proscribe the dual role. Experts are the only witnesses called to give evidence in a court of law who are entitled to offer opinions. This privilege should not be blindly extended to guidance on giving such evidence. It is possible to apply rigorous research to determining best approaches, given knowledge of the concerns which attend the potential complexities of the role, but difficult, not least because ethics committees still struggle to provide the necessary range of expertise to consider research proposals such a field [22]. Reasonable concerns have been cited in respect of, in effect, exceptional potential for offering biased opinion if the person providing the expert report is also the treating clinician. Less often expressed, but no less a concern, is that material which should perhaps properly remain confidential to the clinical relationship cannot it the treating clinician takes on expert roles. Research could identify the nature and extent of such biases, if any, and the nature and extent of harm, if any—to offender-patient or the wider public—when

the treating clinician draws on all information to write a report. The fact that different jurisdictions do operate different approaches to this dilemma suggests that there is no absolutely correct approach, which in turn should reassure ethics committees that there would be nothing unethical in a research comparison of the different approaches.

Take-Home Messages

- Most clinicians will at some point in their career find themselves acting in several roles in relation to a patient, but tensions in this fact are particularly likely to arise for those working between health and criminal justice systems.
- Professional bodies are increasingly providing guidance on how to manage such competition, and clinicians should always follow their professional code and guidance as far as possible, consulting with other clinicians in the field and/or legal advisors if there is any risk of breach.
- There is, however, almost no evidence base for many aspects of such guidance.
- This position could be changed, with interest from and determination on the part of the research community.

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