Forensic Psychiatry and Political Controversy

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This article gives a U.K.-based perspective on the involvement of forensic psychiatry organizations in questions of political controversy. Medical professional bodies are fundamentally concerned to uphold good standards of clinical practice and patient welfare, and to uphold professional medical ethics. In our specialty, when acting as individual expert witnesses, we seek to serve the courts with objectivity and respect for the law. However, as members of our professional bodies we have a legitimate medical concern about how the law affects the mentally disordered as a class. We should articulate a collective view about what treating the mentally disordered justly and appropriately in the legal system means and should challenge the law when it fails to achieve this.

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One of my abiding memories of AAPL's excellent annual meeting in San Antonio in October 2003 was a contrast between two sessions. A workshop entitled *Attorney's Tricks During Expert Testimony*[1] was immediately followed in the program by a panel entitled *Ethical and Cultural Issues in the Forensic Evaluation of the Guantanamo Detainees*.[2] The first of these sessions—a hugely enjoyable and entertaining presentation—was packed by an audience fascinated to observe senior colleagues demonstrating the vulnerabilities of unwary experts and how to avoid them. The second session was very sparsely attended. I had anticipated that it too would be packed, even though it was a late addition to the conference program, but most of the seats were empty.

Which of the two sessions dealt with issues of greater importance? There can be no question that the latter raised questions of profound moral and political significance relating to standards of justice and due process. At the time of writing, approximately 680 individuals from 40 countries detained at Guantanamo Bay, Cuba, are to be tried before U.S. Department of Defense Military Commissions. Some may face capital punishment. Their fate has generated immense international controversy. Traditional criminal law protections such as attorney-client confidentiality, *habeas corpus*, and the exclusion of evidence obtained by coercion do not apply to the detainees. As the conference panel noted: "U.S. psychiatrists will shortly be asked to conduct forensic evaluations of those detainees, raising profound psychiatric cultural issues, and ethical questions that have not confronted the profession for fifty years, if ever" (Ref. 2). Set against these issues, the preoccupations of the previous workshop that attracted so much more audience engagement appeared parochial and frivolous.

What does this contrast reveal about us? To what extent should forensic psychiatrists as a professional body be involved in issues of political controversy, particularly concerning legal standards and human rights?

My first, naïve reaction was that the pattern of attendance would have been different among U.K. forensic psychiatrists. Over here, we seem to enjoy politically charged arguments. In recent years the annual residential conferences of the Forensic Psychiatry Faculty of the Royal College of Psychiatrists have included animated, critical debates, including with government ministers, about the ethics of proposed legislation and mental health policy. But on second thought, I was less sure whether there would have been a difference. It is easier to criticize a neighbor than oneself. In the United Kingdom, we also have not been vociferous about the welfare of groups with a high political profile who are subject to banishment and public fear or hostility, such as asylum seekers and foreign nationals who are subject to potentially

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indefinite detention because they are suspected of involvement with terrorist groups. The latter are held in prison (or high-security hospitals) without charge under the Anti-Terrorism, Crime and Security Act of 2001. These powers of detention involved derogation from the right to liberty under the European Convention of Human Rights and have recently been subject to a high-level critical review.[3]

In the United Kingdom, the great majority of forensic psychiatrists are employed within the National Health Service (NHS) by publicly funded mental health services. Some forensic psychiatrists are employed by independent (private) sector hospitals providing secure units, but the care of their patients is publicly funded. Academic posts in the specialty are mainly funded by the NHS. Very few forensic psychiatrists work predominantly in independent medicolegal practice. Most provide clinical services, and expert witness work is usually a lesser role. This contrasts with our colleagues in the United States for whom the converse may be more usual. Within the NHS we are in a network of complex relationships between the Government (the Department of Health), the NHS bodies responsible for commissioning and managing our services, the criminal justice agencies that seek forensic psychiatry input, and the public.

The degree to which the Government sets both direction and prescriptive detail for health policy, and especially mental health policy, is remarkable. In a recent Department of Health publication, the NHS is described as a system based on partnership, quality, and performance in which the delivery of health care should be measured against national standards, and variations in quality should not be tolerated.[4] There is a drive to build much greater public involvement into NHS structures and professional regulation.[5–7] The Government has issued a national framework of universal standards that all mental health services are expected to provide,[8] together with specific requirements for the provision of crisis resolution and assertive outreach teams, early intervention in severe mental illness and primary mental health care.[9] A cascade of further Department of Health guidance has been issued since 2002 on standards for other psychiatric services and patient groups.[10] Mental health policy places a strong emphasis on public safety,[11] and the Government has proposed radical reforms of mental health legislation[12] to widen the scope of compulsion and reduce the practice of excluding dangerous, personality-disordered people from psychiatric detention on the grounds of untreatability.

This practice has arisen because under England's and Wales' current mental health legislation, the Mental Health Act of 1983, one of the criteria for detaining a person with "psychopathic disorder" is that hospital treatment is likely to alleviate the condition, or prevent deterioration of it. The consequence of a psychiatric opinion that hospital treatment will not achieve this is that psychiatric detention cannot be ordered. From a public policy point of view, this is perceived as a serious lacuna in the public protection that mental health law is expected to provide, and the Government's legislative reform proposals are designed to remedy it.

However, although we operate within this highly prescriptive health policy environment, external and professional regulation of medicine and its specialties is essentially separate from the NHS, with registration and standards of professional conduct being the responsibility of the General Medical Council, and accreditation of training in the different specialties being the responsibility of the Royal Colleges. Joseph Jacob[13] provides a rich, historically based account of the complex guild-like character of such professional organizations, the collective moralities they enshrine, the internal regulation they impose, and their subtle, dynamic, semiautonomous relationships with government and the public. The collective professional moralities that the organizations maintain are not merely self-serving; rather, their fundamental purpose is to protect and ensure standards of medical practice.

Thus, in practice, within the publicly funded NHS, there are arrangements and understandings that recognize professional values, freedoms in clinical decision-making, and, when necessary, the importance of whistle-blowing.[14,15] Although health policy makers, health service managers, and clinicians generally have common purposes and good mutual relationships, there is also always a set of current contested issues, in which professional bodies are involved. Professional organizations are likely to be consulted by the Government in relation to relevant policy and legislative proposals, and some also initiate campaigns and forms of political pressure. Paradoxically, the fact that most U.K. forensic psychiatrists are public sector employees perhaps makes it easier for us than it might be for U.S. colleagues in

private practice to enter openly into disputes about public and social policy and sometimes to oppose government proposals driven by public opinion. We are not dependent for our income on being well regarded by state prosecutors, defense attorneys, or publicly elected judges.

Professional medical bodies are generally expected to maintain and defend two interests: good standards of medical practice and patient care, and the protection of professional ethics. Relevant professional bodies should be involved in matters of social policy and political controversy to the extent that these two interests are at stake. The most prominent recent example of such involvement in U.K. psychiatry has been the stance of the Royal College of Psychiatrists in relation to the government's proposals for reform of the Mental Health Act of 1983. The College considered the proposals to be fundamentally flawed in principle and practicality; its prime objections were ethics-based. It argued that the proposals would seriously damage patients' civil liberties. The College expressed the views that an unacceptably wide range of people would become eligible for detention, and, "no-one should be compelled into treatment or hospital as suffering from a mental disorder solely to prevent criminal behavior."[16] The College's response concluded:

> The College believes that the Draft Bill will, if enacted, result in poorer mental health care and reduced public safety, both being at the further expense of increased stigmatisation of mental illness, stigmatisation within medicine of psychiatry as a specialty and erosion of patients' civil rights. We ask the government to think again and, in light of the widespread opposition to the Bill from all types of organizations concerned with mental health care, to reconsider its intention at this stage to introduce new mental health legislation. A Mental Health Act must be both consistent with the nature of services to which it relates and command support and respect from those directly concerned with its use. Neither condition is satisfied by the Draft Bill [Ref. 16, p 15].

The purpose of giving this example is not to judge the merits of these specific arguments (although they were widely supported), but to illustrate the nature and scope of the interests represented and robustly defended by the organization.

Similar considerations apply to forensic psychiatry as one of the psychiatric specialties within the family of medicine. The professional bodies of forensic psychiatrists should share the two fundamental concerns of other medical professional bodies—namely, to uphold good standards of clinical practice and care for mentally disordered offenders and the protection of professional medical ethics. This is not inconsistent with the view that a different set of principles of ethics may have to operate in the context of the courts when forensic psychiatrists give expert testimony. There is no reason why we cannot, as a professional group, advocate good standards of medical care and welfare for mentally disordered offenders on the basis of traditional principles of ethics of beneficence and nonmaleficence, while at the same time, in the role of individual expert witnesses, recognize that our duty to the court and the imperatives of honesty and objectivity may be incompatible with the avoidance of harm. It is not inconsistent to combine forensic ethics as individuals in court with clinical ethics as a professional organization. To argue otherwise would lead to troubling and unpalatable conclusions. If traditional principles of medical ethics did not form part of the value system of our professional organization, we would lose our rationale for promoting excellence in the clinical practice of forensic psychiatry and treatment services and our basis for evaluating treatment standards.

Furthermore, being partisan as an organization in promoting the welfare of patients is not inconsistent with being neutral as individual practitioners in the adversarial context of the court. An analogous duality is maintained by criminal lawyers. The English Bar Council, for example, which represents the interests of barristers (who provide advocacy in our higher courts) has similar complex functions to the professional medical bodies, including governance of the profession, maintenance of professional standards, and the regulation of education and training. As an organization, the Bar Council sometimes expresses strong opinions and concerns that can be perceived as representing defense interests, although the views are based on concerns about fundamental principles such as the presumption of innocence and a fair trial. For example, it has opposed recent Government proposals[17] that would restrict jury trials and that would allow retrial for serious offenses under certain circumstances.[18] At the same time, the Bar Council's code of conduct is clear that a barrister's overriding duty to the court is to act with independence in the interests of justice, and to promote and protect the best interests of the client (whether prosecution or defense).

In the task of promoting the clinical care and welfare of forensic patients, our professional organiza-

tions might usefully add to their armamentarium of traditional principles of ethics those espoused by Paul Appelbaum for application in the court context—namely, truth-telling and respect for persons.[19] Telling the truth about the clinical care and welfare of forensic patients entails not only promulgating good research on treatment needs, advances, and service effectiveness, but transparency about the limitations, failures, and faults in services and professional care. Historically, we have not been good at recognizing them. (Consider two European examples: the lamentable series of critical inquiries into scandals of cruel and authoritarian institutional care in U.K. mental hospitals during the 1960s and 1970s[20] and, at an incommensurate level of horror, the "euthanasia" program in Germany between 1940 and 1945 in which the extermination of thousands of chronically mentally ill and disabled was implemented in the name of psychiatric reform.[21]) Dr. Appelbaum's second principle of respect for persons is largely expressed by recognition and protection of their constitutional or human rights. Where these are lacking, we should be prepared to say so. (The Guantanamo detainees facing psychiatric evaluation are a case in point.)

The role of our professional organizations in promoting the welfare of mentally disordered offenders may also entail criticism of the law. As expert witnesses in individual cases, we are enjoined to serve the court with objectivity and respect for the law. However, as members of our professional organizations, we have a legitimate concern about how the law affects the mentally disordered as a class. To what extent do the mentally disordered in criminal proceedings experience just and appropriate outcomes? To what extent are their treatment needs met or denied? Does the law operate consistently in exculpating the mentally ill? As clinicians we should articulate a collective view about what treating the mentally disordered justly and appropriately in the legal system would mean, and we should challenge the law when it fails to achieve this.

We might remind ourselves of how forthright our 19th century forebears were in criticizing the law when they thought it failed to achieve justice for the insane. In England, the leading psychiatrist, Henry Maudsley, strenuously criticized the legal test of responsibility that failed to exculpate many who were mentally ill as based on "bad psychology." In consequence:

> . . . when a person whose insanity is suspected is condemned to death, what happens after his trial? Why, that the competent medical skill is then called in to give the competent and impartial help which ought to have been given at the time of the trial, and in fact, to undo quietly in private what has been done with all the pomp and parade of justice wrongly in public [Ref. 22, pp 660–1].

Similarly, several decades earlier in the U.S. Isaac Ray described the common law in relation to criminal responsibility and insanity as: ". . . founded on totally erroneous notions respecting the nature and phenomena of this disease, and consequently has led to frightfully numerous cases of judicial homicide" (Ref. 23, p 254). Ray[24] firmly believed the law should change in the light of new psychiatric knowledge and resolutely pursued this view.

The pursuit of knowledge, allied with professional concern for the welfare of the mentally disordered, offers a way forward in relation to controversies over the death penalty. Following the U.S. Supreme Court declaration in the case of *Atkins v. Virginia*[25] that, in the light of emerging standards, it was unconstitutional to execute the mentally retarded, Alan Stone, writing in a U.K. journal, has suggested that ". . . the abolitionists, many of whom are forensic psychiatrists, should be documenting the mental disorders of the almost 4000 death row inmates and laying the groundwork to argue that it is also cruel and unusual to execute the mentally ill" (Ref. [26], p 491).

Our professional organizations should support this enterprise. To do so would be consistent with their core purposes.

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