Guest Editorial

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The traditional image of the forensic psychiatrist as an expert witness in the courtroom dominates public and professional concepts of the functions of the members of our Academy. We also think of ourselves as having the functions of educators, lawyers, judges, and juries about psychiatry in areas relevant to specific and general legal questions.

Some new roles have developed for the forensic psychiatrist, and if they are to become established as they should, they must be given adequate acknowledgment and support by the members of the Academy. Unlike the roles alluded to above, these are concentrated within the psychiatric hospital and the psychiatric office. One might be designated a clinical forensic function, the other a new teaching role.

Laws affecting psychiatry (*i.e.*, its practitioners, patients, and practices) are no longer directed at psychiatric institutions and involuntary patients. These newer laws have become so broad and pervasive that they now require of psychiatrists a rich understanding of legal philosophy (not merely "law") as an integral, substantive consideration in determining the optimal approach for fulfilling society's and the medical profession's responsibility to the severely mentally ill to return them to as near a state of health as medically possible, as soon as possible, with minimal constraints on their liberties — (physical, mental, and civil). These laws have developed out of statute and case law.

Unfortunately, psychiatrists have been slow to recognize that the law is two-edged sword, that it can serve not only to prevent and interfere with the application of appropriate, humane, and effective psychiatric care to the mentally disabled but that, applied with thoughtful, concerned and medico-legal sophistication, it can facilitate and insure that the mentally disabled reeive proper care. It can, and should, serve, when appropriate, as part of the therapeutic armament.

Schwarz and Greenfield recently reported a case in which a patient physically assaulted a staff member who then brought suit against the patient. The litigation proceeded, and the court found the patient responsible for this behavior. She received a suspended sentence. Between the time the charges were brought and the suit decided, as well as

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the post-suit period, the patient remained in treatment and showed improvement in her condition.

Sacks and his collaborators described a case, in a recent issue of this *Bulletin,* in which a patient who was neither homicidal nor suicidal, submitted a "sign-out letter" as a resistant to treatment (as well, perhaps, as a test of the sincerity of the staff's desire to be helpful to the patient). The therapist decided to insist on court-ordered commitment, telling the Mental Health Information Service lawyer and the patient that "any other course of action would endanger [the patient] in an unwarranted way." The patient responded with a greater degree of improvement than he had demonstrated in his six prior hospitalizations during the preceding eight years.

This was an instance in which due process was used by the staff as "an affirmative mode of therapeutic communication with the patient." That communication appears to have been a statement to the patient that "You are an individual with rights and the power to obstruct what your doctors feel would be an approach in your own best interest. We will not withdraw because you have brought in the courts. We will stand by you and insist that there is merit and validity in our evaluation, and we will make what effort we can to stop you from harming yourself. However, you are not our adversary, your disease process is. It may prevail, but we will continue to try to work with you as long as you and the courts allow us to do so."

In cases such as this, the forensic psychiatrist can provide the important amalgam of substantial familiarity with the dictates of the law, the psychiatric needs of the patient, as well as familiarity with the psychiatric capabilities of the facility. There is no other professional as well qualified to assist in planning psychiatric therapeutic programs in cases that involve legal considerations. By virtue of his training and experience with the law, as well as with therapeutic techniques and needs, the consultant forensic psychiatrist can play a crucial role in arriving at the most informed evaluation of what is both legally and psychiatrically optimal. The forensic psychiatrist can assist the hospital and the clinician to determine at what point efforts are likely to be quixotic and at what point real gain is likely to be made by risking venture into the legal arena.

It is time for hospital administrators and staff to request forensic psychiatry consultations early. A timely consultation with a forensic psychiatrist can be as therapeutic and helpful to the treatment program for a particular patient as a timely consultation with a neurologist, a psychopharmacologist, or a psychoanalyst. Once litigation has begun, a hospital lawyer may have his understanding of the interplay of legal and clinical considerations in the case enhanced by consultation with a forensic psychiatrist. This is especially likely in the case of general hospitals, where the lawyer has not concentrated in the area of legal psychiatry.

The other new role for the forensic psychiatrist is one that is restricted to the confines of the psychiatric hospital, consulting room, and training

program. The role is educational, designed for the clinical psychiatrist and psychiatric resident. Psychiatric education continues to confine itself largely to clinical, theoretical, and laboratory aspects of the field. Psychiatric educators have yet to realize that the psychiatrist, more than at any other time in the history of his profession, requires an intimate knowledge of the law (statutory and case), of workings of legal process, and of trends and patterns of judicial interpretations of the law.

While I have just used the phrase, "the law," too few psychiatrists appreciate that there is no such fixed and stable entity. The law is only what the last judge interpreted it to be, and that interpretation can be relied upon only until the next judge offers his or her interpretation. As Judge David O. Boehm observed, in this *Bulletin,* ". . . it is apparent that it is not only in psychiatry that classifications and labels change. It happens in the law as well. However, the law operates at a very decided advantage because, as Chief Justice Taft once pointed out, 'The Constitution is what the Supreme Court says it is,' and at a somewhat less elevated level the law is what judges say it is."

While nobody can predict with true reliability how a jury or an appellate court will decide, those familiar with the process can weigh the probabilities unencumbered by naive illusions. We have seen too many generations of psychiatrists uneducated in the legal realities of their patients' worlds and psychiatric treatments. Teaching the complexities of criminal insanity and competency to stand trial is not enough, essential as these are. Psychiatrists must get an adequate education in courtroom functioning; in legal philosophies and principles that affect psychiatry and its patients in such areas as valid consent to various treatment modes; involuntary, voluntary, and informal psychiatric hospitalizations; legal implications of states of dangerousness for psychiatrists and for their patients; and the heterogeneous legal criteria for the heterogeneous civil and criminal competencies that the same person, simultaneously, may have and not have.

At this time, our obligation to serve as consultants and educators to the psychiatric profession has a claim upon us equal to our older role as consultants and educators to the legal profession.

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